

01/24/96



A literary look
at pathology

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JANUARY 19 1996

Students,
residents must
examine each
other

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DOI drops proposed amendment regarding HCFA 1500 claim form

UPDATE: Physicians must use universal claim form for billing insurers but not for billing patients directly. BY KATHLEEN FURORE

[SPRINGFIELD] Responding to concerns expressed by ISMS and the American Dental Association, the Illinois Department of Insurance will remove a proposed amendment to the Uniform Medical Claim and Billing Forms Act that would have required physicians and other health care providers to use the HCFA 1500 universal claim form for direct patient billing, according to Ron Kotowski, assistant deputy director of the Life and Health Compliance Section of the Illinois Department of Insurance. ISMS and the ADA opposed the amendment, which ISMS Chairman of the Board Ronald G. Welch, MD, said "clearly goes beyond the statutory intent" of

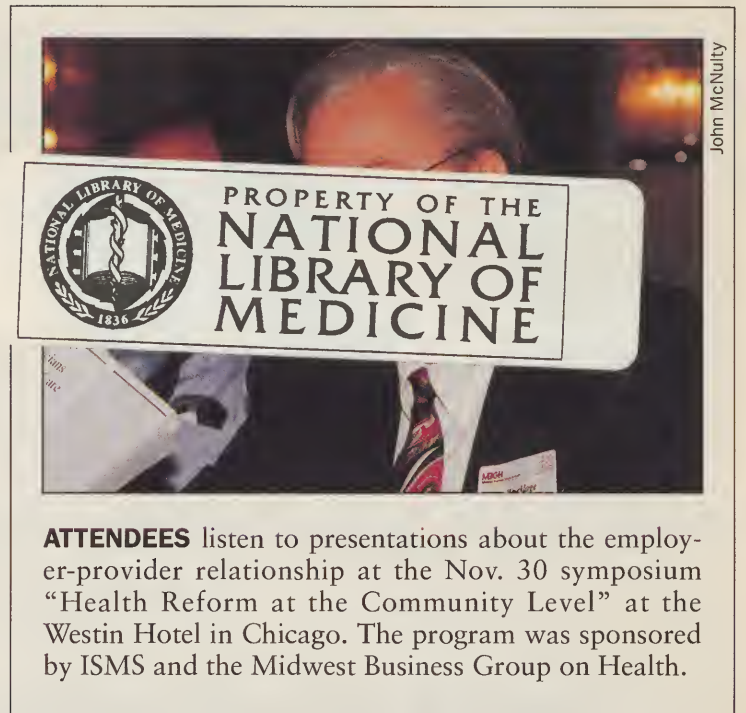
the legislation. The exemption applies only to direct patient billing.

The act, which Edgar signed in September 1994, requires "providers of health care or treatment, medical services, dental services, pharmaceutical services or medical equipment" to use the HCFA 1500 universal claim form for all bills submitted to insurers as of Jan. 1, 1996. Doctors now must use the forms to provide information about a patient's medical diagnosis, treatment and prognosis, as well as to list charges in conformity to the proof requirements of an insurance policy or a hospital, medical or dental service contract, according to the legislation.

The department kept in mind "comments with respect to superbills and [the] HCFA 1500 form," DOI Director Mark Boozell wrote in a Dec. 11, 1995, letter to a physician who had expressed his concerns in a letter to Gov. Jim Edgar.

"We are going to remove the language that states practitioners have to use the 1500 form to bill patients directly," Kotowski said. The DOI's intent was to prevent physicians from billing patients instead of insurers if those patients would ultimately have submitted the bills to payers. In a recent phone survey of insurers, the department learned that payers do not receive a significant

(Continued on page 14)



John McNulty

ATTENDEES listen to presentations about the employer-provider relationship at the Nov. 30 symposium "Health Reform at the Community Level" at the Westin Hotel in Chicago. The program was sponsored by ISMS and the Midwest Business Group on Health.

Chicago-area physicians merge practices to create PO

ORGANIZATION: Primary care doctors form Mid-America Medical Group. BY KATHLEEN FURORE

[OAK BROOK TERRACE] Hoping to maintain clinical autonomy and high-quality patient care, 63 primary care physicians in DuPage and west Cook counties have merged their practices and the assets of their 23 businesses to create the Mid-America Medical Group, a physician organization.

"This is an organization owned by doctors to run doctors," said Norman Webb, chief executive officer of the group's management services organization. "Being a fully integrated group practice gives the physicians economies of scale. They share staff, lawyers, accountants. It reduces their outside consulting fees." It also enabled the doctors to purchase a more sophisticated information system.

"I certainly had my concerns

about merging my practice - it was a bold step," said James Dan, MD, president of the Mid-America Medical Group. "But as Norm Webb says, we're giving up management autonomy to preserve clinical autonomy. We don't have to call every 800-number [for permission to treat a patient]. We're trying to control medical quality."

Morgan Meyer, MD, a member of the new group and a past president of ISMS, also said the PO will alleviate bureaucratic hassles. "We felt we would have better clout if we were running our own show and not having every prescription questioned."

The physician organization, which is organized into four areas covering the western suburbs, was begun in early 1995

(Continued on page 14)

ISMS workshop focuses on physician-driven entities

In January and February, ISMS members have the opportunity to attend a Society workshop that provides an in-depth look at successful physician-driven managed care organizations. The three-and-a-half-hour program is free and is being conducted at various locations across the state, including the Chicago Medical Society's Midwest Clinical Conference in Chicago. The workshop informs members about ISMS' proposed Physician Services Organization, state and national market trends and managed care under capitation.

The workshop was held in Peoria on Jan. 17 and in Springfield on Jan. 18. Programs will also be conducted in Champaign on Jan. 24 at Jumer's Castle Lodge, 209 S. Broadway; in Rockford on Feb. 7 at the Clock Tower Inn, 7801 E. State St.; in Carbondale on Feb. 8 at the Holiday Inn-SIU, 800 E. Main St.; and in Collinsville on Feb. 15 at the Holiday Inn Collinsville, 1000 Eastport Plaza Drive. Each workshop runs from 5 to 9 p.m., and dinner is provided.

Please watch your mail for more information or call the ISMS division of governmental affairs at (800) 782-ISMS. In addition, look for coverage in Illinois Medicine.

A special session of the workshop will be conducted at CMS' Midwest Clinical Conference on Jan. 20 at the Sheraton Chicago Hotel & Towers, 301 E. North Water St. Separate registration is required. ■

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Seminar helps
residents
negotiate,
interview



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Transportation safety board issues air bag warning

[WASHINGTON] The National Transportation Safety Board is asking hospitals and physicians to help warn the public about the risk that air bags pose to infants and small children. After studying seven recent low-impact accidents in which passenger-side air bags were deployed, killing, or severely injuring children, the organization announced its decision to conduct an education campaign.

"The safety board believes that in each of the accidents the child would have survived the accident with minor or no injuries had the air bag not been deployed," said NTSB Chairman Jim Hall in a Nov. 2 letter to the administrator of the National Highway Traffic Safety Administration.

In a recommendation to the American Hospital Association, the safety board said hospitals with obstetrics units should conduct a mail campaign warning anyone who has given birth in the past year about the dangers of placing a rear-facing child safety seat in the front seat of a vehicle with a passenger-side air bag. In many of the accidents studied, children suffered skull fractures and

crushing brain injuries "as a result of the impact of the air bag compartment cover flap with the back of the child safety seat at the location of the child's head," Hall's letter said. It advised hospitals to issue the same warning to participants in childbirth education programs and other new parenting classes. The board also recommended that members of the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians and the American Academy of Pediatrics issue the air bag warning.

Infants are not the only ones in danger. Some of the older children injured or killed in the accidents studied were not restrained or were improperly restrained with lap and shoulder belts. As a result, they were too close to the air bag compartment module and were struck in the head and upper body by the air bag at its peak force, Hall explained.

The safety board stressed, however, the good that air bags can do. Data from the NHTSA show that air bags can reduce the chance of death in front-end crashes by 20 percent to 40 percent. ■

Meetings examine health of individuals, communities

[CHICAGO] Urban community leaders of various health care organizations gathered Oct. 25 at a series of town hall meetings convened by Sinai Health System to focus on the needs of the inner city. The series, called "Healing Bodies, Building Lives," was conducted at Mount Sinai Hospital Medical Center.

A discussion about the delivery of health care in underserved communities was led by Edward Lawlor, director of the Center for Health Administration Studies at the University of Chicago. He asked the group to develop a report card listing criteria to assess community needs. "Report cards are becoming more and more popular in the health care industry," he said. "What gets measured gets done."

The report card should include medical information, said ISMS President-elect Sandra Olson, MD, who participated in the discussion. "For example, we need to know the reporting rates of immunizations, sexually transmitted diseases, tobacco and alcohol usage, access to prenatal care, teen-age pregnancy and the many different forms of cancers." Each of these areas profoundly affects the viability of a community, and without those data, a community would not have access to a system that met its health care needs, she explained.

"Throughout the United States, there are notable successes in improving the health and vitality of communities, and we must find a way to build on those successes," said Benn Greenspan, president and CEO of Sinai Health System. "At SHS, we have learned that the health of individuals is inextricably linked to the well-being of their community. Jobs, economics, education, housing, safety and the fundamental social infrastructure of a community are essential to its health and to its very viability."

Other participants in the discussion noted that the economic status, values and educational systems in the commu-

nity should also be assessed.

Sinai Health System, established last year, is a West Side health care network that includes Mount Sinai Hospital Medical Center, Schwab Rehabilitation Hospital and Care Network, Sinai Medical Group and Sinai Community Institute. ■



STATE REP. Ann Hughes (R-McHenry) spoke to physicians about tort reform legislation at the McHenry County Medical Society dinner meeting, held Dec. 20 in Algonquin.

Children's Advocacy Center opens suburban satellite

[HAZEL CREST] Responding to the need for support to deal with child abuse and neglect in the southern suburbs, the Chicago-LaRabida Children's Advocacy Center has opened a satellite center in Hazel Crest, said a spokesperson for LaRabida Children's Hospital and Research Center.

"Currently, 20 to 25 percent of Chicago-LaRabida Children's Advocacy Center clients are from southern Cook County," said Fred Nirde, director of the center. "The Hazel Crest satellite center will make it easier for victims and families to receive the services they need without having to travel far from their home."

One of the programs offered by the new center is the Victim Sensitive Inter-

vention Program, which streamlines the investigation process and helps prevent the inadvertent re-victimization of children during that process, explained a LaRabida news release. The center plans such initiatives as court advocacy, short-term group therapy for young victims and support groups for nonoffending parents. "The VSI program is only one part of the process for victims of child abuse or neglect and their families," said Neil Hochstadt, LaRabida's vice president of behavioral science.

In related news, the Department of Justice's Office of Juvenile Justice and Delinquency Protection designated the Midwest Regional Child Advocacy Center of LaRabida Children's Hospital and Research Center as one of four regional child advocacy centers nationwide. The MRCAC will help communities in 12 states identify issues they could face while developing programs to curb child abuse. The child advocacy center will help the communities establish programs, identify and link up with local resources, and train professionals and community volunteers to work with abused children and their families, a news release said.

"Child abuse is a growing problem in not only the cities, but the suburbs and rural areas as well," Nirde said. "While child abuse may be more prevalent in large population centers, it happens throughout our communities, and each area may have a different capacity to treat these children. The MRCAC offers resources that can strengthen their current programs or facilitate the establishment of programs where none exist."

In Illinois, for example, 328,000 cases of child abuse were reported in 1992 alone. Almost 50 percent of those reports came from the less densely populated regions of the state, the release said. ■

Top 20 reasons for outpatient visits (By patients surveyed in the United States, 1993)

Reason for visit	Number of visits	Percent distribution
All visits	62,534,000	100.0
Progress visit	6,593,000	10.5
Routine prenatal examination	3,900,000	6.2
General medical examination	3,140,000	5.0
Postoperative visit	1,394,000	2.2
Well baby examination	1,364,000	2.2
Stomach and abdominal pain, cramps and spasm	1,121,000	1.8
Cough	1,119,000	1.8
Skin rash	806,000	1.3
Fever	795,000	1.3
Earache or ear infection	728,000	1.2
Back symptoms	716,000	1.1
Medication, other and unspecified	655,000	1.0
Head cold	622,000	1.0
Headache, pain in head	620,000	1.0
Depression	608,000	1.0
Counseling, not otherwise stated	510,000	0.8
Other and unspecified diagnostic tests	500,000	0.8
Prophylactic inoculations	492,000	0.8
Hypertension	480,000	0.8
Knee symptoms	479,000	0.8
All other reasons	35,892,000	57.4

Source: U.S. Dept. of Health and Human Services, National Center for Health Statistics, "Medical Benefits," Nov. 15, 1995



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Seminar helps residents negotiate, interview

PREPARATION: More options bring more challenges to new physicians. BY JANICE ROSENBERG

[CHICAGO] When asked how often they hear from recruiters, residents attending an ISMS Resident Physicians

Section seminar last fall answered with a question: "Do you mean how many times a day?" Today's new doctors looking for post-residency practices are being courted by a variety of physician-recruitment services. In fact, some report offers in cities ranging from Chicago to Timbuktu.

Although having a lot of choices is exciting, it can complicate decision-making. That's one reason the program "Paving the Way to Practice: The Business Side of Medicine" aims to help residents enhance their business skills, including decision-making and negotiation, said David P. Schmiede, the program facilitator and the consultant who helped develop the program. "After three to five years of clinical training, residents haven't had much opportunity to develop business skills. When the time comes to consider contracts from potential employers, they haven't learned to

negotiate," explained Schmiede, president of MedStrategies Consulting Group in Burr Ridge. "As a result, residents sign poor contracts where they don't understand the ramifications. They focus on salary and benefits, but they don't think about future possibilities like



Schmiede

(Continued on page 10)

Workshop lays the foundation for practice

Today, medicine is practiced in a dynamic climate that requires financial and managerial skills as well as clinical expertise. To help residents make sound decisions to launch their careers, ISMS' Resident Physicians Section offers the program "Paving the Way to Practice: The Business Side of Medicine," presented by David P. Schmiede, president of MedStrategies Consulting Group. About 60 residents from around the state attended sessions on Oct. 28 and Nov. 4, 1995, and another is scheduled for Feb. 4 in Springfield.

The day-long workshop is divided into four parts, each addressing a critical aspect of establishing a medical career. The first segment focuses on employment opportunities, advises residents on selecting a location and practice structure, and reviews practice options in areas such as occupational health. Specifically, criteria are given for evaluating the options of solo practice, group practice, hospital affiliation and managed care entities like HMOs. In addition, this section provides practical information on such topics as group division of income and considerations in assessing the financial status of a practice.

The second section walks residents through each step of the interviewing process, from preparing a CV to evaluating an interview. It includes questions that candidates are commonly asked and questions they should consider asking prospective employers.

Contract evaluation is the subject addressed in the third part of the program. Residents learn which provisions should be included in every employment or buy-in agreement; how to find, evaluate and work with a health care consultant, attorney or accountant; and how to negotiate effectively.

The final segment covers financial topics such as budgets, life and disability insurance, investments, retirement plans and estate planning. Because of the current economic climate, savings and loan associations look closely at the loan applications of young physicians, who typically have a large debt load, little business experience and no assets – but great potential. Savings institutions require specific information, which is outlined in the seminar. The workshop prepares residents to project an image of responsibility.

For more information about the Feb. 4 workshop, residents may call (312) 782-1654 or (800) 782-ISMS, ext. 1241. ■



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REPORT for Illinois Physicians

MEDICARE

LABORATORY TESTS UTILIZING AUTOMATED EQUIPMENT

Medicare covers the following twenty-two (22) common laboratory tests when performed in groups or combinations on automated equipment.

ALANINE AMINOTRANSFERASE (ALT, SGPT)
ALBUMIN
ALKALINE PHOSPHATASE
ASPARTATE AMINOTRANSFERASE (AST, SGOT)
BILIRUBIN, DIRECT
BILIRUBIN, TOTAL
CALCIUM
CARBON DIOXIDE CONTENT
CHLORIDE
CHOLESTEROL
CREATININE

CREATININE KINASE (CK, CPK)
GAMMA GLUTAMYL TRANSFERASE (GGT)
GLUCOSE
LACTATE DEHYDROGENASE
PHOSPHORUS
POTASSIUM
PROTEIN, TOTAL
SODIUM
TRIGLYCERIDE
UREA NITROGEN (BUN)
URIC ACID

Payment will now be made only for those tests in an automated profile that are medically reasonable and necessary. Where some of the tests in a profile are covered, payment cannot exceed the amount that would have been paid if only the covered tests had been ordered. For example, the use of a 12-test profile to determine the blood glucose level in a proven case of diabetes is unreasonable because the result of a blood glucose test performed separately provides the essential information.

Physicians are encouraged to limit their test ordering solely to those tests that are related to specific symptoms and disease conditions. Medicare will pay only for tests that are medically reasonable and necessary, and it will not pay for routine screening tests.

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EDITORIAL

Resolving to use common sense

Based on comedians' routines and media coverage, you'd think everyone was making New Year's resolutions. But more than 60 percent of Americans won't even try to make them in 1996, according to an AMA survey.

In medicine, resolutions can be opportunities for patients to make changes leading to a healthier lifestyle and for physicians to enhance the physician-patient relationship through better communication. Certainly, there are always obstacles to communication – a shortage of time, for starters. In addition, some managed care plans are using confidentiality clauses in contracts to prohibit doctors from talking to patients about proposed tests and treatments prior to plan authorization, reported the New York Times. A director at the Medical Society of New Jersey said these clauses "discourage physicians from talking openly to patients about the need for specialty care and the role of managed care companies in limiting tests and treatments."

But open communication is at the heart of the physician-patient relationship. And thankfully there are no restrictions on counseling patients about lifestyle changes they need to make. For example, do you regularly discuss exercise with sedentary patients? Half of all American adults get little or no physical exercise, according to an epidemiologist at the University of Minnesota, as reported in the New York Times.

Another resolution might be to help patients make sense of contradictory survey results or avoid overemphasizing them. The benefits of drinking red wine have been widely touted, but some patients are ignoring the proviso "in moderation." Before Christmas, the British Medical Association Journal released survey results claiming that wine has a "superior ability to kill illness-causing bacteria in food," according to the Boston Globe. The findings created a "media frenzy," helping Europeans justify their love affair with wine. Do your patients feel free to discuss such studies with you, including their personal application of the results?

A study reported in a December issue of JAMA maintained that a "strikingly high percentage of patients treated at two large public hospitals couldn't read or understand basic written medical instructions." The rate was particularly high for patients over 60. If the study results are representative, this is disturbing news because it coincides with trends toward early patient discharge from hospitals and expectations for greater patient responsibility in health care. Physicians can help alleviate the situation by avoiding medical jargon and verbalizing their instructions, researchers said.

When you get down to it, resolutions are nothing more than the regular application of common sense to solve a problem – not such a bad idea after all. ■

PRESIDENT'S LETTER

How can the AMA reinvent itself?

Raymond E. Hoffmann, MD



The report advocated representation based on specialty, involvement in managed care, gender, ethnic background and stage of career.

The recent AMA meeting was filled with important issues. While we were in Washington, D.C., the budget battle was just warming up. I hope that by the time you read this, it will be over and the government will be back on track.

With this historic confrontation as a background, the AMA is struggling to become more representative of all physicians. This would make the AMA more relevant when it seeks to speak for the "house of medicine." A major concern of legislators is that although the AMA is the largest physician organization, its membership is composed of less than 50 percent of U.S. physicians. The AMA is concerned because it could speak with more authority during negotiations if other physicians' organizations were not expressing differing views.

How can that be done? How can the AMA make itself new in these new times in this new year? A 200-member study group sent the AMA's House of Delegates a report called the "Study of the Federation," which recommended sweeping changes in the way in which delegates and trustees are chosen. This whole process started with the conclusion that the AMA is best-positioned to make its membership more inclusive.

The report advocated representation based on specialty, involvement in managed care, gender, ethnic background and stage of career in addition to the traditional proportional representation from states. These more narrowly defined organizations now exist, and most of us belong to some of them.

Of course, change creates problems. Those who have learned and succeeded under the current rules are suspicious of change. This includes some state organizations and small specialty organizations that have worked to get their members to join the AMA.

Those suspicions do not arise just from fear of losing influence. Some organizations are run by a few elite physicians such as department chairmen. And other organizations were created as educa-

tional entities but are now trying to become political lobbying groups.

The proposed AMA revamp would result in more than 650 delegates. There are only 535 people in Congress to run the entire United States!

Another major concern is whether all of us could be represented by multiple organizations. For instance, a young African-American female orthopedic surgeon in an HMO could be represented by as many as eight different votes. Is that fair? In Congress each citizen is represented by only three votes from three people, two senators and a representative.

Recently, organizations fighting for large increases in their delegations have gone to Washington and made separate agreements. Is it fair to give more voice within the AMA to organizations that have made its work harder, even if there is no requirement to stick to the majority decision?

So how do we solve this problem? Medicine needs to speak with one voice. We need to figure out how to iron out our differences inside our own organization before we go public with issues.

Over the years we have often heard that the AMA no longer stands for "my beliefs." It is accused of being distant and of not understanding what the solo practicing physician in rural Illinois or the HMO physician in Chicago needs.

Well, now is the time to tell the AMA. This debate is not over specific issues but over how issues in the future will be decided.

Do you want to be known by membership in a national organization – based only on geography – or are you now more inclined to consider yourself a member of a specialty group or a managed care organization?

The AMA is trying to make sure it is relevant in the coming years. You can help. Contact your AMA delegate or me through ISMS or write a letter to Illinois Medicine. Do it now. Please! ■

GUEST EDITORIAL

'Twas the night before Christmas,
and ... here come some lawyers

By T. Evan Schaeffer

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There was astonishing news this December about Santa Claus. High-placed sources report that last month, Santa invited several of the nation's top law firms to meet with him at the North Pole. Apparently at wit's end, Santa told the assembled lawyers that he's facing a growing array of legal problems that may slow or even stop his yearly visits to American children. He then served the lawyers cocoa and asked if they could help.

Although much of the story is still vague, the North Pole moved to quell some of the speculation last week when it took the unprecedented step of holding a news conference in Duluth. The details provided to reporters paint a sorry picture of the growing litigiousness of the American character, as well as the complications caused by the vast web of legal rules and regulations that characterize American society. Santa's spokesman suggested that this Christmas, it might be wise to ponder what's gone wrong. He gave some troubling examples:

To Christmas aficionados, both young and old, it's well known that Santa's reindeer, having been specially bred to fly long distances in the air, are the animal of choice for the difficult job of pulling Santa's sleigh. Nonetheless, it's now official that Santa is under investigation by American's own Equal Employment Opportunity Commission, which is exploring a complaint by an Alaskan dog breeder that the job should be opened up to other four-legged creatures. The new sleigh-pullers would include not only dogs with previous sled-pulling experience, but also moose, bear and even muskrats. Understandably, Santa is uncertain how to respond.

In another development, Santa was informed by the Environmental Protection Agency that he faces fines and possible jail time for other legal transgressions. According to a letter he received by certified mail, Santa is in violation of the Clean Water Act every time the flying reindeer relieve themselves over an inland waterway. Although Santa protested to the EPA that he rarely flies over open water, the agency replied that it would "shut down the entire works" if he didn't institute an environmental compliance program within 90 days.

Then, unbelievably, there are the lawsuits. Although Santa has always had to defend the occasional products liability action, a new legal theory is now finding its way into American courtrooms. Apparently goaded on by greedy parents, a number of children are suing because they weren't satisfied with what they got

on previous Christmas mornings. According to one class-action petition, brought on behalf of all children living within the jurisdiction of New Jersey, Santa "failed to live up to the promise of the season" and "tortuously caused plaintiffs to experience headaches, stomach cramps and vomiting when, on Dec. 25, they didn't find all they asked for beneath the Christmas tree."

Though legal experts have roundly condemned this "sour grapes tort" as meritless, judges everywhere are reluctant to dismiss the lawsuits until Congress acts first. Caught in the middle, Santa plans to make use of a video system that will record his dialogue with the children who sit on his lap. In addition, he'll ask obvious troublemakers and their parents to sign a release form. Santa's spokesman told the journalists that he has abolished his longstanding

practice of withholding presents to naughty children. "In this day and age," the spokesman said, "it's just too risky."

High-placed sources report that the lawyers who met with Santa were appalled by what they learned.

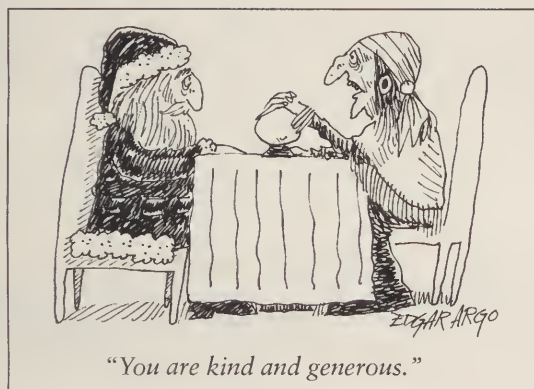
The formerly jolly St. Nick complained that his insurance rates have quadrupled and that he spends at least six weeks a year dealing with forms and other paperwork. "Nothing is simple anymore," he said. In one instance, a group of Louisiana cops, fearful of the rise in domestic terrorism, forced him to submit to a strip search before they would let him cross the border into the state. "Humiliating," Santa told the lawyers.

When asked at the news conference whether it wasn't the lawyers themselves who were to blame for the country's problems, Santa's spokesman replied that his boss had considered, but then rejected, this possibility. "You Americans live in a democracy," the spokesman said. "You all share the blame equally. My advice is catch hold of the Christmas spirit and try to apply it all year long to your social interactions."

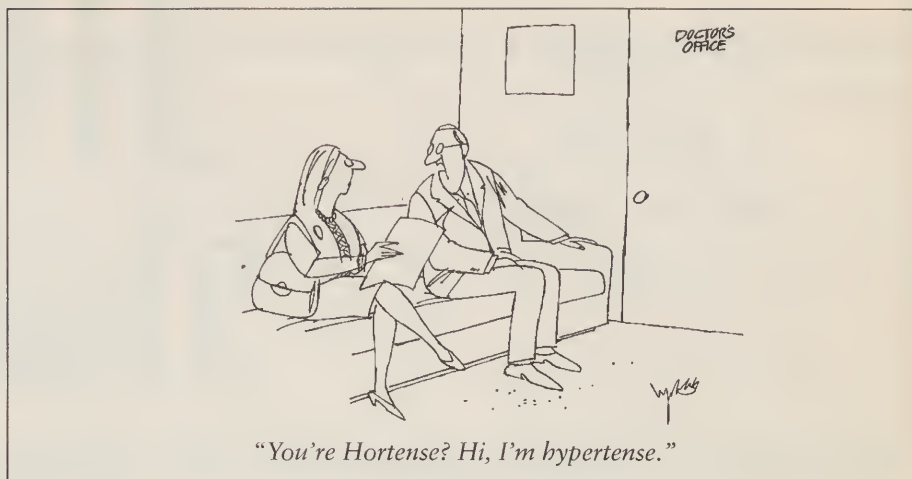
Surprisingly, Santa is a big defender of lawyers these days. According to sources, he laughed with delight when one of the law firms visiting the North Pole told him how he could pay for the cost of legal representation. Here's the idea. Since he owns the rights to his own image, Santa can generate huge revenues by charging advertisers to use his likeness in their ads. By licensing his image, Santa will tap into a steady source of income that he can use to pay his legal counsel.

"Santa loved the idea," his spokesman said. "He thinks it's very American." ■

T. Evan Schaeffer is an attorney and freelance writer from St. Louis.



"You are kind and generous."



GUEST EDITORIAL

A painful look at how we die

By Ellen Goodman

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The newspaper comes to my doorstep this morning bearing its daily quota of obituaries. A teacher has died at 65. A costume designer at 81. A civic leader at 70. A company executive at 69.

The lives of these people are described as if the death notice were a resume. The causes of death — cancer, heart failure — are included as if disease itself were a flaw in the human system that science has yet to fix.

What is missing from these pages — what is always missing — are the descriptions of how they died. Was the teacher in pain or at peace? Did the executive have a living will and a doctor who listened? Did the civic leader linger attached to a machine? Was the designer's death one she designed?

I read these pages wondering what it would be like if we listed the way of death as well as the cause of death. Would that make a difference?

Last week, something remarkable happened. The newspapers in this country ran a story about a scientific breakthrough. A research project begun with high hopes to test ways of making death in the hospital more humane was pronounced a failure, DOA.

The flop was on Page 1, 20 years after Karen Ann Quinlan lapsed into a coma. It came after a whole generation of talk about high-tech dying and living wills and the right to die.

When the Robert Wood Johnson Foundation funded this eight-year study, there was a growing consensus among ethicists and doctors about how to change the way of dying. If doctors really were sure of the prognosis of a patient, if they knew what patients wanted and didn't want, surely there would be less pain, fewer "heroic measures" and more care in the hospital care of the dying.

So, the study's project called SUPPORT — Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments — placed nurses in five teaching hospitals to facilitate these changes. But as Dr. Joanne Lynn, a co-director of the project says, "We did what everyone thought would work, and it didn't work at all, not even a quiver."

Half of the patients still died in pain. Huge gaps remained between what patients said they wanted and what doc-

tors did. Living wills didn't help. There was too little talk, too late. Too many people died alone, attached to machines.

The easy villains of the story would be the paternalistic doctors who remain convinced they know what's best for the patient even if the patient disagrees. There's enough truth in that image to make Boston University ethicist George Annas warn that "if dying patients want to retain some control over their dying process, they must get out of the hospital if they are in and stay out of the hospital if they are out."

A more benign interpretation is that the culture of medicine — from school to training to practice — teaches doctors to regard death only as defeat. Even when dealing with the terminally ill, they talk about life and death decisions when they are really dealing with death and death decisions.

But Dr. Lynn believes that the problem runs deeper than doctors who don't listen. "This wasn't a group of doctors dedicated to finding the last possible date on the tombstone. What we learned was that the conspiracy of silence about death was stronger than we expected, and the force of habit was also stronger than we expected."

On a day-to-day basis, neither doctors nor patients were talking about what the patients wanted. They were both following the cultural script, talking about the next chemotherapy, the next procedure.

They were patching, fixing, going from crisis to crisis without ever asking, "How can I live well while dying?"

"We are all involved in the dance of silence," believes Dr. Lynn. Even families going through this painful process wanted one thing: "to pass the mirror test. They want to be able to look at themselves when it's all over and say, 'I was a decent person.'" Close up, that "decency" is still defined as fighting death. But when you stand back from the mirror, as this study does, it's a sorry reflection.

Hospitals are not the only places where we die. There are hospices and homes. There are as well the "tender mercies" of Dr. Kevorkian and the moral ambiguities of doctor-assisted suicide.

But the majority of Americans end their lives in hospitals. As long as hospitals reject a humane role in helping people die, we are failing dismally as doctors, as friends and as fellow travelers through what the psalmist calls "the valley of the shadow of death." ■

Students, residency programs must examine each other

SEMINAR: Residents and program directors share interview tips. BY MARY NOLAN

[OAK BROOK] Making the right match is the whole point of interviewing medical students for residency programs, but both sides need to check each other out thoroughly, according to speakers at the ISMS Medical Student Section's ninth annual "Preparing for Residency Interviews" seminar held last fall in Oak Brook. Students heard from resident physicians who shared their interview experiences and program directors who

represented various specialties.

"[Interviewing] is really a matching process where we try to weed out those [students] who would not fit into our program," said Warren Wallace, MD, director of post-graduate education at the Department of Medicine at Northwestern University's McGaw Medical Center in Chicago. "It is critical that we communicate to our applicants the kind of program we have so [residents selected] can

be happy." He noted that students must put their best foot forward while being honest with the interviewer about their interest in the program. "Believe me, none of us will be happy in August if the program is not what you expected."

The resident physicians explained to students the potential opportunities and pitfalls of certain specialty programs. For example, anesthesiology is facing difficulty because the market is saturated.

Pediatrics, however, is experiencing physician shortages, a problem that presents tremendous opportunities for students interested in that field.

"There are a lot of medical pediatric programs surfacing at hospitals. You need to know about them," said Robert Oliver, MD, a resident physician in the Department of Medicine and Pediatrics at Southern Illinois University's School of Medicine. He suggested that students make a list of the programs they are interested in, including descriptions of the physical surroundings of those institutions. "This is important because you're going to be there for years and you need to be happy where you're at," Dr. Oliver said.

During the interview, "you must ask questions – hard questions – about the program that you're interested in," advised Mitchell Glaser, MD, a psychiatry resident physician at the University of Chicago Hospitals and a resident member of AMA's Council on Medical Service. He suggested asking about the program's goal for residents and the resident's role in caring for the patient.

"You must be honest [in everything you say] and be prepared to sell yourself in the first 60 seconds," Dr. Glaser said. "[Program directors] are looking for someone who will be a leader."

Interviewing is "a two-way interaction where you're trying to learn as much as you can about a program and the program is trying to learn as much about you," said Samuel Gotoff, MD, chairman of the pediatrics department at Rush-Presbyterian-St. Luke's Medical Center in Chicago.

"Remember," he said, "medical schools provide information about you, and you get letters of recommendation, so the program director is learning something about you from paper." Most important, the interview is a way for students to distinguish themselves from what's on that paper, he added.

Many resource materials are available to help students determine which hospital program best meets their needs, said Michael Rainey, PhD, associate dean of student affairs at Loyola University's Stritch School of Medicine at the Maywood campus. For example, information on U.S. residency programs and institutions is available through the AMA's Fellowship and Residency Electronic Interactive Database Access System.

The seminar's keynote address was given by Sandra Olson, MD, ISMS' president-elect and a neurologist in Chicago. She told students the practice of medicine is changing by leaps and bounds, and those changes will continue at a rapid pace for years. "You, as doctors, need to seize and keep the reins of control of medical practice for the patient. It won't be easy, but this revolution is just beginning. I think physicians are just starting to realize their potential power in this [managed care] arena."

Dr. Olson centered her address on the "seven Cs" of medical care in the 21st century: change, control, competition, culture, communication, community and caring. Using the metaphor of "sailing those seven Cs," she said: "I envision these waters as often turbulent and rough, especially for those unprepared for the journey. But, from what I have seen, I am confident that the medical students and residents of today are better equipped than we were as they get ready to practice after the year 2000."

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ISMIE Update

Watch for
coverage of
how to close a
practice

Case in Point

Factual records help prove contributory fault

BY RICK PASZKIET

When dealing with patient non-compliance, physicians should make sure they accurately document specific related evidence. This factual record is vital to



prove comparative or contributory fault, which is defined as noncompliance that is

more than 50 percent responsible for a poor medical outcome.

Case #1

The case in brief: In February 1986, an Ob/Gyn read a patient's Pap smear as a class 3. The physician used cauterization to treat her for cervical inflammation and told her to return for another examination in three months. The patient, however, did not return to the Ob/Gyn until five years later. Once again, the Pap smear results revealed class 3 cellular atypia consistent with low- to moderate-grade dysplasia of the cervix.

Although the physician recommended an immediate diagnostic biopsy, the patient did not return to see the physician until early 1992, three months later. At that time, the physician advised conization rather than a punch biopsy, since the patient had previously been treated with cauterization. The patient, who was trying to become pregnant, refused the procedure after the physician told her that it would delay her attempted pregnancy by at least six months.

Beginning in fall 1991, the physician advised the patient about the seriousness of her Pap smear results several times. On two occasions, the physician recommended a biopsy, but the patient refused. The Ob/Gyn documented those refusals in the patient's chart and recorded the fact that he showed her a videotape on cervical cancer. The physician also sent her a certified letter underscoring the importance of having a biopsy.

The patient became pregnant in September 1992 and deliv-

ered her baby in April 1993. Pap smears during and after the pregnancy were normal, so the physician decided that a biopsy was unnecessary. However, a Pap smear performed in April 1994 was again a class 3. A biopsy was finally performed, revealing cervical cancer that had spread throughout the patient's uterus. Further medical treatment was unsuccessful, and the patient died of cervical cancer in June 1995.

The patient's estate sued the physician for failing to diagnose cervical cancer. After the jury concluded that the patient was more than 50 percent responsible for the outcome, the verdict was returned in favor of the physician.

Case #2

The case in brief: A 38-year-old patient discovered a lump in her right breast and consulted her Ob/Gyn. The physician described the abnormality as a "fullness of the right breast" and recommended a mammogram. Four days later, a mammogram was performed, and the results were negative.

Nevertheless, the physician told the patient to return for a follow-up examination in two weeks, when she completed her menstrual cycle. However, the physician failed to schedule an appointment for the patient. When his nurse called the patient about returning for a follow-up examination, the patient refused to come in. The physician then spoke directly to the patient, explaining the importance of another examination. Once again, the patient refused to see the doctor. These conversations were never documented in the patient's file.

Six months later, the patient noticed a change in the nipple of her right breast. She saw another gynecologist, who referred her to a surgeon. A biopsy revealed breast cancer, and the surgeon performed a modified radical mastectomy.

The patient sued the first Ob/Gyn for failing to diagnose her breast cancer. The case was settled in favor of the plaintiff.

The points these cases make:

Both cases demonstrate the need to keep a strong factual record to prove a patient's contributory fault.

"In contributory fault, you have to prove that the patient is more than 50 percent responsible for the medical outcome," said attorney Keith Emmons, a principal in the Champaign law firm Dobbins, Fraker, Tennant, Joy & Perlstein. "This proof depends on accurate records that clearly indicate that the patient deviated from a doctor's advice. You have to show what the patient did or did not do."

The enactment of H.B. 20 has significantly changed how juries are instructed regarding the contributory negligence standard in Illinois, Emmons said. "The same law is basically still in effect. However, the jury is no longer instructed that a plaintiff [who is more] than 50 percent at fault cannot recover damages. The jury renders its verdict, but the court must take away the judgment if the jury finds the patient is 50 percent at fault."

Without reliable documentation, the determination of patient negligence may be reduced to the word of the physician against that of the patient. That can be a problem for doctors. "Physicians are presumed by juries to know more about medical issues and treat-

ments than the patient," said Bill Anderson, a partner in the Chicago law firm Lord, Bissell & Brook. "Contributory fault has to be based on direct and specific records. Otherwise, you risk alienating the jury by blaming the patient. The first case clearly illustrates that the patient was given the necessary knowledge about her condition and that she knew the consequences of failing to follow the doctor's advice."

"The physician in the second case had inadequate documentation," Anderson continued. "Once the patient refused to come in for another consultation, the doctor, knowing the seriousness of the case, should have recorded her refusal in the patient's chart and sent her a certified letter that repeated his warnings."

"You need some type of record to demonstrate that your medical advice was given to the patient, and that the patient understood what you were saying," concurred Robert LaPata, MD, an Ob/Gyn in Evanston. "When a patient refuses to listen to your advice or fails to have a test done, the doctor has to respond in a prompt and serious manner. This means sending a certified letter that tells the patient in bold language that you are not responsible for his or her case if the patient contin-

ues to ignore your advice."

Emmons explained that the physician must document that he or she made an "extraordinary effort" to warn the patient about the possible results of failure to follow the physician's advice.

"In short, physicians have to show that they tried their best," Emmons explained. "In a case of contributory fault, the physician cannot seem aloof or unresponsive."

The physician's first obligation is to make sure that the noncompliant patient understands the severity of his or her medical condition, said Melvin Gerbie, MD, a Chicago Ob/Gyn.

"By showing the patient a videotape on cervical cancer, the doctor in the first case took that extra step to protect himself as well as the patient. The American College of Obstetricians and Gynecologists has produced a series of such videos that are a great help to doctors confronted with such noncompliant patients."

"The doctor has limited control over the patient's actions," Dr. Gerbie said. "You can't force a patient to come in or have a test done. But a doctor does have a great deal of control over the patient's records. This means that every test, every appointment missed and every patient discussion should be carefully noted in the patient's chart."

"Case in Point" uses hypothetical case history to illustrate loss-prevention maxims.

MALPRACTICE ROUNDUP

Physician obtained informed consent for laser therapy

A California jury found that a general surgeon had fully informed the parents of a 4-year-old patient regarding the potential risks and complications of laser therapy, according to the August 1995 issue of *Medical Malpractice Law & Strategy*.

In *Uriarte vs. Navas*, the patient's parents took her to the physician for treatment of wart-like lesions on her neck. The physician performed laser therapy, after which the child developed a large keloid scar. The parents alleged the physician failed to obtain proper informed consent and to warn them of the potential risks and complications of the procedure. They also claimed the physician's treatment was substandard because it was administered to a Hispanic patient, who was more likely to develop keloid scarring than a lighter-skinned individual would have been. However, the physician's records showed he had discussed treatment alternatives with the parents and that he had informed them about possible scarring.

The ruling confirmed that laser therapy was an appropriate treatment for the patient's condition, according to the article.

MEDICAL ESSAYS



A LITERARY LOOK AT PATHOLOGY

Medicine can be both art and science.

By Janice Rosenberg

It isn't every day you find a book that examines the cosmic significance of life through essays on dissection practices in 17th century Bologna or Aristotle's explanation of semen. Nevertheless, such a book has been written by pathologist F. Gonzalez-Crussi, MD. What may be truly unusual for this kind of esoteric work is that it hasn't been relegated to obscurity: Last fall it received a glowing review in the New York Times.

"One reason I like to write essays is the freedom that the form gives," Dr. Gonzalez-Crussi said. "If I decide to write about mummies, it doesn't mean I'm going to have to confine myself to ancient Egypt. You start writing with that, and you can wander off and write about anything as long as you do it with some measure of credibility and you come back to the original theme without appearing to be too rambling. Nonetheless, it gives you sufficient freedom that I don't exaggerate when I say you can really talk about anything that you want."

The book, "Suspended Animation: Six Essays on the Preservation of Bodily Parts," is the physician's sixth published literary work. Dr. Gonzalez-Crussi began writing in the early 1980s, drawing on his work as a pathologist for inspiration and dipping into his personal experience to illustrate his ideas.

You wouldn't have anticipated a literary career based on his background, however. Dr. Gonzalez-Crussi was born in Mexico City to a family of "limited means." After finishing medical school in Mexico, he completed a residency in pathology at the University of Florida. He worked as a pediatric pathologist in Canada until 1978, when he assumed his current position as head of the department of pathology at Children's Memorial Hospital in Chicago.

In discussing his career choice, Dr. Gonzalez-Crussi looks critically at the paths that brought him to pathology. "It's often difficult for a person to say why he chose one thing over the other. Some say I must be obsessed with death to have chosen pathology, but I don't think that's true."

Instead, the choice grew out of more prosaic circumstances. Two medical school professors who became Dr. Gonzalez-Crussi's role models were pathologists. He described one as European, distinguished and erudite, and the other as dynamic, young and handsome. "As a young student I didn't see such shining

Steven Daiber

MEDICAL ESSAYS

examples in other specialties," he said.

Then there was pragmatism. Dr. Gonzalez-Crussi considered ophthalmology, but he worried that acceptance into any surgical residency program might be more difficult because of his foreign background and the heavy competition for relatively few slots. Pathology residencies were available, so Dr. Gonzalez-Crussi signed on.

"I think my personality was probably not fit for my becoming a surgeon," he said. "I see that now. Surgeons have to have a boldness and an ability to make lightning decisions that I lack. I like to take one thing and look at it from all sides."

Second, he wanted to be able to write — at that stage of his career, he was interested in writing textbook chapters and journal articles. He postponed taking up a more literary style until he was nearly 50 years old.

That postponement stemmed in part from his uncertainty about his ability to express himself in English. In addition, the study of pathology absorbed him, leaving him little time for the in-depth reading and research he knew would be required for the kind of literary writing he wished to pursue.

"Sometimes I think I should have written when I was younger and had another view of life," he said. "I probably would have accumulated more prestige as a writer. After all, that was one thing that I wanted to do, to become a writer. But on the other hand, then I would not have done what I did in the medical profession and advanced to the stage where I wanted to advance."

Eventually the time was right. "I thought that if I waited to do what I always wanted to do until after my retirement, I might not have the energy or would be more easily discouraged," he said. "I decided I had

to do it because it was a personal quest."

Like his choice of specialty, his choice of subject material was practical. Hoping to avoid painful rejection letters, he looked for a way to make his writing different by drawing on experiences that were not common to most people.

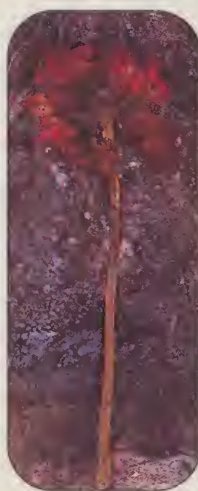
"So even though it was a little lugubrious to talk about cutting up dead bodies, I think I have demonstrated that the subject can be approached elegantly and that it is one that is worth reading about," Dr. Gonzalez-Crussi said.

His first books, "Notes of an Anatomist" and "Three Forms of Sudden Death," grew out of professional interests. Then, to show that he could also write about subjects outside his field, he wrote "On the Nature of Things Erotic" and "The Five Senses." Of the former he joked, "That shows I can write about things for which one does not have to be dead."

After writing "The Day of the Dead," based on his Mexican childhood, he returned to his original subject matter in "Suspended Animation." This most recent book was partly inspired by photographer Rosamond Purcell, whose photographs accompany the text, and partly suggested by his publishers, who thought his original subject would respond to the public's current interest in death and dying.

Dr. Gonzalez-Crussi said he views his audience as the general literate reading public. He does not write specifically for physicians, nor does he believe they necessarily make the best readers. "Their responsibility is so great that they see the time they are investing in something else as time away from their becoming more proficient in taking care of patients," he said.

(Continued on page 10)



DISSECTION IN BOLOGNA

Excerpt from "Suspended Animation: Six Essays on the Preservation of Bodily Parts," copyright ©1995 by F. Gonzalez-Crussi, reprinted by permission of Harcourt Brace & Company.

In 1405 the University of Bologna allowed up to twenty students at the dissection of a male corpse, and up to thirty at a female's. In the following century the demand became so great that amphitheatres had to be built in order to accommodate the audience. In Leiden, the apse of a church, of the former Falie Baginhof, became the Theatrum Anatomicum that functioned from 1593 to 1773. In Padua, at the Palazzo del Bo, the magnificent anatomical amphitheater with its concentric oval tiers, was built in 1594 and saw the like of Galileo and Morgagni deliver lectures. The superb Bolognese amphitheater in the Archiginasio is another example.

Dissections were public and were widely advertised days ahead. In Bologna, notices were posted on columns of the Archiginasio, in Latin, which was the language of the lessons. In Leiden, since anatomical dissection took place in a church, the tolling of a bell summoned the spectators. In Paris, the streets adjoining the School of Medicine were decorated with garlands, flowers and festoons. Successful physicians, prominent members of the com-

munity, intellectuals and the inevitable idle and rich snobs, apart from medical students, gathered in the amphitheater. This motley crowd generated no small commotion with gossip, bumptiousness, and self-display. Liveried lackeys appeared who circulated amidst the attendees distributing bouquets and oranges to the ladies, that "the perfume of the ones and the sweet aromas of the others" assist them in brooking the unpleasantness of the emanations wafting to their noses from the opened cadaver. Members of the aristocracy received sticks smeared with aromatic resins, which were to be burned during the performance as one more expedient against revolting odors. In Bologna, the front seats were reserved for important officers, the prior, the counselors and the electors.

The Bolognese amphitheater was magnificently decorated for the occasion: the walls were hung with damask, and two large torches, placed respectively at the head and feet of the cadaver, illuminated the working area. A crimson-gowned professor then appeared, ceremoniously followed by his attendants, and silence descended upon the amphitheater. The prior (whose prerogative it was to interrupt the demonstration at any time by clapping his hands) gave the ceremonial order to begin. The professor used all the ornate erudition of which he was capable to review, in flawless academese, the work of his predecessors; he would then lay out the chief points of the demonstration that was about to unfold. ■

A literary look

(Continued from page 9)

"But because what I write is inspired by what a segment of doctors do, I think it would be enjoyed especially by physicians," he explained. "And there are doctors who are avid readers. Even medical students have asked me to sign the book or give them advice. I've been invited by medical societies to speak, and colleagues have written reviews of my books in medical journals."

The New York Times book review probably best sums up the appeal of Dr. Gonzalez-Crussi's topic and his latest work: "Death for us is what sex was for the Victorians: something that fascinates and frightens us, an inevitability that we do not speak of, a scandal that makes a mockery of our pretensions to grandeur, dignity, transcendence. Dr. Gonzalez-Crussi has delivered a missive that, though the envelope may give off a whiff of formalin, is in its essence a love letter to life, in all its strangeness, beauty and mystery." ■

Seminar helps

(Continued from page 3)

salary escalations and contract renewals."

In the last year of their training programs, residents begin being courted by recruiters – a relatively new phenomenon, said Mary L. Agnello, who also spoke at the program. Weeding through all the material they receive is not easy for residents in the midst of busy, stressful training. "Twelve years ago, when I started working in this field, physicians were [still] going into private practice and had their own small businesses, so recruitment wasn't an issue," explained Agnello, president of Staff Development Corp. in Brookfield, Wis. "In today's environment, physicians have a different relationship with their careers. Now, more than ever, [they] will be employees."

Change has become the norm, she told the group. "The era of establishing a practice and staying in one place for your whole career is pretty much history. Statistics show that 75 percent of you will change your practice within five years and that you will change it a total of three times before you retire."

In addition to helping residents negotiate contracts, the seminar teaches them interviewing strategies. For example, residents can role-play responding to questions potential employers will probably ask, said Schmiede, a participant in the Society's Consultant Referral Network. Because employers will consider commu-

nication skills in their evaluations, Schmiede helps residents verbalize what they want in a practice situation.

That is particularly important when residents interview with private practices, he said. Although recruiters for large medical systems may focus on residents' clinical qualifications and training background, private practice physicians may want someone who shares their medical philosophy and will feel comfortable in their community.

RESIDENTS SHOULD ALSO PREPARE to ask questions. Schmiede readies residents for upcoming interviews by supplying them with 25 to 30 questions they should ask potential employers. And they should ask them at the first interview to eliminate practices that aren't a good fit, he said.

Ask how many physicians have left the practice in the past three to five years, how many physicians on staff are board-certified and whether any have had malpractice problems, Schmiede advised. Residents should also inquire about the clinical styles of the other physicians in the practice as well as their lifestyles.

"Find out how the practice is addressing health care reform," Schmiede said. "Are they approaching it in a reactive or proactive stance? Are they doing nothing because Clinton's plan fizzled, or have they just invested \$35,000 in a computer system because they know that they'll need a way of capturing data if they're going to compete in the years to come?" ■

MEMENTO MORI

In January 1995, a play based on Dr. Gonzalez-Crussi's personal essays was presented at Chicago's Live Bait Theater. Adapted by the theater's artistic director, Sharon Evans, the production used a multimedia approach that included puppetry, sculpture and film.

"If the subject matter was death, we wanted to be extremely animated on stage as a counterpoint," Evans said. "The set was an abstract representation of a cadaver, and all the action took place inside the body."

The play was well-received by critics and drew a very strong response from the medical community, Evans said. One night the house was sold out to medical students from Loyola University. After the play, the students participated in a discussion with Dr. Gonzalez-Crussi.

Despite his initial skepticism about turning his essays into theater, Dr. Gonzalez-Crussi enjoyed the play, although he said he found it strange to watch an actor wearing one of his own lab coats.

"One thing that's interesting in the business of writing, you never know when someone might want to do something with your work," Dr. Gonzalez-Crussi said. "To me that's very rewarding and different from medical writing. In six or seven years, the textbooks I've written are obsolete, but there's a chance that years from now, people might still enjoy reading my essays." ■

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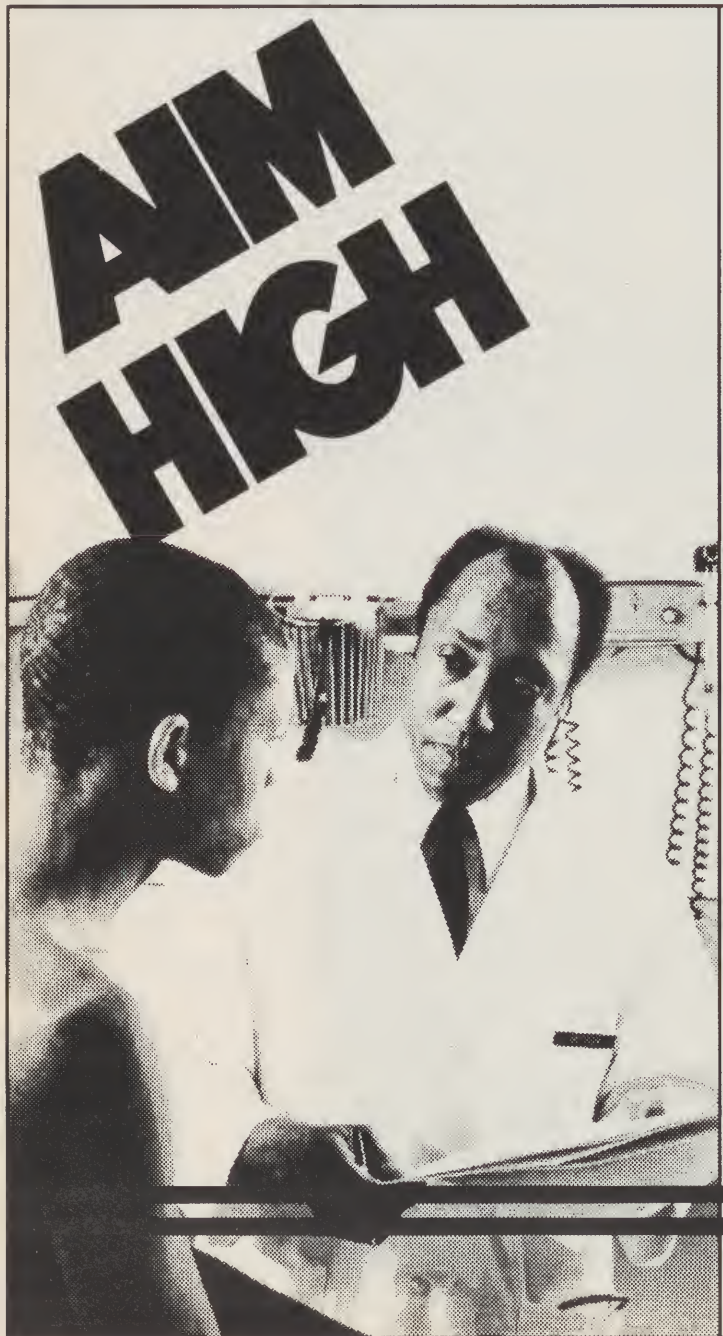
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Send ad copy with payment to Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602; (312) 782-1654, (800) 782-ISMS; fax (312) 782-2023. Illinois Medicine will be published every other Tuesday except the first Tuesday of January and July; ad deadlines are four weeks prior to the issue requested. Although the Illinois State Medical Society believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify advertisements at its discretion.

Illinois/nationwide: Need internist, family physician, pediatrician, dermatologist, Hem/Onc, Ob/Gyn, rheumatologist and more. CV to Stan Kent, SKA, P.O. Box 904, Tremont, IL 61568; (800) 831-5679.

Belleville/Fairview Heights and St. Louis: Premier group is seeking BC/BE physicians in internal medicine. This is an excellent opportunity for the physician who wants to concentrate on patients, not paperwork. Excellent salary, bonus, good call schedule, paid malpractice, vacation, CME and an outstanding 401(k). Send CV to Rick Klos, Group Health Plan, 940 West Port Plaza, St. Louis, MO 63146; or call (800) 743-3901 or (314) 453-1700.

Acute Care Inc., emergency medicine/locum tenens: Seeking quality physicians interested in emergency medicine or primary care locum tenens positions. Full time and regular part time. Numerous Illinois, Iowa and Nebraska locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact Acute Care Inc., P.O. Box 515, Ankeny, IA 50021; phone (800) 729-7813 or (515) 964-2772.

Excellent opportunities for physicians in the Chicago and suburban areas. Single-specialty and multispecialty group practices, hospital-based and outpatient arrangements. Competitive compensation and benefit packages. For a confidential inquiry, contact Debbie Aber, (708) 541-9347; Physician Services, 1146 Parker Lane, Buffalo Grove, IL 60089; fax (708) 541-9336.

Illinois, southwest of Chicago: Part-time physician. Seeking experienced BC/BE physician for work in a moderate-volume, rapidly growing Level II trauma center hospital 60 miles southwest of the Loop. Excellent compensation, includes paid malpractice. Contact Steven Taller, MD, FACEP, Morris Hospital, 150 W. High St., Morris, IL 60450; (815) 942-2932, ext. 1158.

Family practice, internal medicine, Ob/Gyn and urgi-care physicians needed to join single-specialty and multispecialty group practices located within one hour of downtown Chicago. Congenial practice settings with well-trained colleagues. Competitive compensation packages include a full range of benefits. Utilize a modern 420-bed hospital located close to the physician offices. Great lifestyle with numerous social, cultural and recreational activities available. For additional information, call Martin Osinski at (800) 327-1585, ext. 132.

Excellent income opportunity – part-time work. The Medical Laser Institute of America is looking for physicians (otolaryngologists, dermatologists, plastic surgeons and sclerotherapists) to work two to four half-days per week, flexible hours, performing laser procedures. Everything is provided by the institute, from patients to supplies. Please forward your CV to the Medical Director, The Medical Laser Institute of America, 606 Potter Road, Des Plaines, IL 60016. Or call (708) 298-0719 to arrange for an interview.

Internal medicine: Full-time or part-time BC/BE internist needed to join a busy practice in Chicago's northern suburbs. Please send replies to Box 2287, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Busy dermatologist in southwest Chicago suburbs seeks BC/BE dermatologist for partnership. Fax CV to (708) 361-8083.

Classified Advertising Rates

	25 words or less	26 to 50 words	51 to 75 words	76 to 100 words
1 insertion	\$ 7	\$17	\$25	\$ 42
3 insertions	13	32	46	78
6 insertions	18	44	64	108
12 insertions	22	53	79	132

Confidential box numbers: Add 18 words to the word count and a \$5 surcharge.

Delavan, Wis.: No call – no hospitalization required! We are actively recruiting BE/BC internal medicine physicians to practice at the Riverview Clinic located in Delavan, Wis. (population 6,000), located 30 minutes south of Janesville. Delavan is a safe, family-oriented community with excellent schools and recreational opportunities on a lake in the community. Excellent compensation and benefits are provided, with employment leading to shareholder status. Contact Stan Gruhn, MD, Riverview Clinic, P.O. Box 551, Janesville, WI 53547-0551; phone (608) 755-3520.

North Shore suburbs/internal medicine: Northwestern-trained BC internist with busy North Shore private practice is seeking a full- or part-time associate. Independent or employee position is possible. Please send replies to Box 2281, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Physician, part-time and/or full-time: Relaxed environment. Fax resume and salary history to (708) 272-0078.

Opportunity for physician: Established or newly licensed MD for practice of general medicine. Share in the care of patient clientele. Opportunity for growth and possible assumption of practice. For confidential interview, phone (317) 447-1412 Monday, Tuesday or Thursday, or phone (317) 447-1693 after 4 p.m.

Fast track: Chicago. Full- or part-time faculty at Mount Sinai Hospital Medical Center. One-third occupational medicine patients. Opportunities for board certification in occupational medicine. Top-dollar compensation and benefits, including CME and medical malpractice insurance. Contact Leslie Zun, MD, at (312) 257-6843.

Malpractice case evaluation: Board-certified medical experts needed. All specialties. All locations. Defense and plaintiff cases. Excellent remuneration. Interested physicians, please contact and send CV to Barry Gustin, MD, FACEP, American Medical Forensic Specialist, 2991 Shattuck Ave., Suite 302, Berkeley, CA 94705. Phone (510) 549-1693, fax (510) 486-1255.

FAMILY PRACTITIONER ...

Want to share call with 11 other Family Practitioners and live in the Brainerd Lakes area? Immediate opening available at Brainerd Medical Center.

Brainerd Medical Center, P.A.

- 30 physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162-bed local hospital – St. Joseph's Medical Center

Brainerd, Minnesota

- In the middle of the premier lakes of Minnesota
- Less than 2½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families



Call Collect to Administrator:

Curt Nielsen
(218) 828-7105 or (218) 829-4901
2024 South 6th Street
Brainerd, MN 56401

Brainerd Medical Center, P.A.

Delavan, Wis.: No call – no hospitalization required! We are actively recruiting BE/BC family physicians to practice at the Riverview Clinic located in Delavan, Wis. (population 6,000), located 30 minutes south of Janesville. Delavan is a safe, family-oriented community with excellent schools and recreational opportunities, on a lake in the community. Excellent compensation and benefits are provided with employment leading to shareholder status. Contact Stan Gruhn, MD, Riverview Clinic, P.O. Box 551, Janesville, WI 53547-0551; phone (608) 755-3520.

Southeast Chicago: Obstetrician. Illinois license, DEA required. In-house position available evenings and weekends. Flexible scheduling. Malpractice insurance provided. Pleasant work environment. Please contact Diane Temple, (708) 654-0050, or fax your CV for confidential consideration to (708) 654-1203.

Benton, Ill.: Franklin County Hospital is seeking two physicians to staff its emergency department. This is a career position with an annual remuneration in excess of \$97,000. Professional liability insurance procured on your behalf. Qualifications include a minimum of two years of emergency department experience and ACLS. For more information, contact Ed Kennedy, Coastal Physician Services, at (800) 326-2782, or fax your CV in confidence to (314) 291-5152.

Illinois: Physician managed group seeks certified primary care physicians to provide clinical services in ambulatory care, fast-track and emergency medicine environments. City, rural and urban opportunities. Flexible scheduling. Malpractice insurance provided. Please contact our VP of Physician Recruitment, (800) 654-6374. Interested candidates may also fax their resume for immediate and confidential consideration to (708) 654-1203.

Janesville, Wis.: Dean Medical Center, a 350-plus-physician, private, multispecialty group is actively recruiting a BE/BC internist for our Riverview Clinic in Janesville, Wis. (population 50,000 – located 40 miles southeast of Madison). Janesville is a beautiful, family-oriented community with excellent schools and abundant recreational activities. Currently, there are 12 internal medicine physicians at the Riverview location. The call schedule will be one in 12 for weekdays and weekends. Excellent compensation and benefits will be provided, with full-time employment leading to shareholder status in two years. Contact Stan Gruhn, MD, Riverview Clinic, P.O. Box 551, Janesville, WI 53547-0551; phone (608) 755-3520.

Robinson, Ill.: Crawford Memorial Hospital is seeking two primary care physicians to staff its emergency department. This is a career position with an annual remuneration in excess of \$110,000. Professional liability insurance procured on your behalf. Qualifications include a minimum of two years of emergency department experience and ACLS. For more information, contact Ed Kennedy, Coastal Physician Services, at (800) 326-2782, or fax your CV in confidence to (314) 291-5152.

Medical directors: Kansas, Missouri. Respected managed care plans seek licensed, board-certified MDs for medical director positions. Candidates experienced in managed care, CQI, utilization review and case management, with minimum three years' clinical experience. Contact Michael Shirley Associates Inc., 220/299, 7300 W. 110th, Suite 230, Overland Park, KS 66210.

General internal medicine – Long Grove: Immediate opening with well-established private practice. Part-time, three office days per week, 30-percent week-night call, 25-percent weekend call. \$65,000/year. Fax resume to (708) 634-2140.

Morrison, Ill.: Morrison Community Hospital is seeking a primary care physician to staff its rural health clinic in Prophetstown, Ill. Hours of operation are 9 a.m. to 5 p.m., Monday through Friday, with one on-call weekend per month. This is a career position with an annual remuneration of \$96,000. Professional liability insurance procured on your behalf. Qualifications: BP in primary care. For more information, contact Ed Kennedy, Coastal Physician Services, at (800) 326-2782, or fax your CV in confidence to (314) 291-5152.

Lake Michigan shoreline community: Join 85 physicians at an integrated health care system in southeastern Wisconsin. Enjoy working in a progressive organization with eight family physicians and affiliate with two local hospitals. Excellent call coverage, no obstetrics, and an attractive income package. Easy access to both Chicago and Milwaukee. For more information, call Susan Pierce at (800) 243-4353.

Assistant medical director – insurance medicine (Wisconsin): Career opportunity exists in southeastern Wisconsin for a decisive, proactive, board-certified primary care physician. Join the headquarters medical staff of a premier insurance company. Requires licensing in Wisconsin and willingness to pursue board certification in insurance medicine. Corporate work week with no call coverage. Earn a competitive salary and benefits. Contact Wade Christoffel, Fox Hill Associates, 250 Regency Court, Brookfield, WI 53045; (800) 338-7107; fax (414) 785-0895. Retained search consultants.

Correctional/academic psychiatrist: The Isaac Ray Center and Cermak Health Services, both nationally recognized forensic mental health teams, seek a full-time, flexible-schedule BC/BE psychiatrist to provide clinical supervision and clinical and academic services in the psychiatric facilities of the Cook County Jail. You will be an employee of the Isaac Ray Center, with a faculty position at Rush Medical College. The position does not involve nor require specialized forensic evaluations for court/testimony. Send CV with inquiry to Roxane Sanders, MD, Cermak Health Services-Psychiatry, 2950 S. California, Chicago, IL 60608; (312) 890-5618.

Illinois: Immediate opportunity for a board-certified or -prepared family physician to join three others in multispecialty group of nine physicians in Ottawa, Ill. The Ottawa Medical Center, P.C., is a state-of-the-art complex affiliated with 155-bed Community Hospital of Ottawa. Practice includes an excellent call schedule and competitive financial package. Ottawa, located about 90 minutes from downtown Chicago, is surrounded by four beautiful public parks and offers one of the finest educational systems in the state. For more information, contact Steve Baker at (800) 430-6587 or fax CV to (309) 685-2574.

Pediatrician needed part time. Bilingual, English/Spanish preferred. Clinic setting. Call (312) 522-5200, Mrs. Gomez.

ENT practice established with excellent volume. Participates in private pay and HMO. Will send information upon request. Send replies to Box 2288, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

No assembly lines here: FPs, IMs and Ob/Gyns at clinics owned by and affiliated with North Memorial don't hand patients off to the next available specialist. Guide your patients through their entire care process at one of our 25 practices in urban or semirural Minneapolis locations. Plus, become eligible for \$15,000 on start date. Interested BC/BE MDs, call (800) 275-4790 or fax CV to (612) 520-1564.

Midwest: Physician-managed group offers excellent full-/part-time emergency medicine/ambulatory care opportunities in Illinois, Indiana, Iowa, Missouri, Wisconsin and surrounding states. Clinical and administrative positions in supportive environments. To learn more about our practice, please contact NES/Midwest, Diane Temple, Director of Physician Recruitment, at (800) 654-6374; fax (708) 654-1203; 440 East Ogden, Hinsdale, IL 60521.

Situations Wanted

Board-certified, experienced radiologist seeks hospital or clinic position. Experienced in interventional radiology, MR and all types of imaging modalities. Please send replies to Box 2284, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Board-certified IM physician seeks part-time, three to four months of primary care work or locum tenens position (summer months only). Page me, (312) 997-1623, anytime.

Experienced, board-eligible diagnostic radiologist available for part-time or full-time position in Chicagoland area. Proficient in all imaging modalities. Call (708) 328-2759.

Experienced, board-certified gynecologist seeks hospital association, primary care association and/or to take over an active practice in gynecology or family practice. Please send replies to Box 2273, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Board-certified IM physician seeks part-time or full-time position in Chicago or north-west suburbs. Extensive experience. Please send replies to Box 2287, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Certified gynecologist/family physician seeks association/locum tenens. Available for office practice. Please send inquiries to Box 2212, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Administrative practice manager/medical transcriptionist available for part-time position, could turn into full-time. Excellent references. Please send replies to Box 2289, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Board-certified osteopathic family physician seeks full-time position (MD or DO) affiliated with teaching hospital in Chicagoland area. Extensive managed care experience. Available summer 1996. Please send replies to Box 2286, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

For Sale, Lease or Rent

For sale: Used Ob/Gyn office equipment/furnishings. Inquiries: (618) 283-1622 or VOGA, 929 Walton Drive, Vandalia, IL 62471.

Commercial offices: Lovely professional two-story building with frontage on Route 68 just north of Route 72 in established East Dundee. There are seven office suites that are fully rented with long-term leases. Good rate-of-return investment. 7,200 square feet of quality space. Newer roof, completely blacktopped for 50 cars. Backup package available. \$625,000. Call Judi Falbisaner at (841) 428-LADY.

Three new exam tables for sale. Will take best offer. Please contact Stephen if interested, (800) 259-6269.

Gorgeous condo office suite: This condo is on the main floor and is in like-new condition. It has a reception room, front office, private office, three exam rooms and lab. Currently leased to a dentist. Are you tired of outdated office space? It's time to move, with all conveniences. Busy street, in-town location. \$150,000. Call Judi Falbisaner at (841) 428-LADY.

Oak Brook Terrace medical office to share/sublease. Fully furnished, X-ray diagnostic lab, treadmill, Holter, etc. Freestanding building, high visibility, parking (Summit Avenue). Call (708) 629-6700.

Naperville: Outstanding medical space for lease: 1,110 square feet in an 18,000-square-foot medical center. Three examination rooms, private office, reception area, administrative area, waiting room and private restroom. Excellent location – immediately off Ogden Avenue. Contact Bill Waliewski, McWilliams & Associates Inc., at (708) 357-9044.



Illinois State Medical Society and its Component Societies Present Alaska

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From \$1,729

per person, double occupancy
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July 5-12, 1996 • July 12-19, 1996
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(Other departure cities available.)**

Whatever your vision of Alaska, reality exceeds imagination. Just as a Celebrity cruise exceeds expectations. In many ways the two are perfectly suited with uncompromising attention to the finest details. Celebrity is like no other cruise line

afloat, and Alaska is certainly unlike any other place on earth. We invite you to explore the very best of Alaska on board the Horizon where the pleasures are plentiful. The cuisine is among the best afloat designed by internationally acclaimed chef Michel Roux. Given all it has to offer, the Horizon has earned a reputation for elegance with a casual ambiance among passengers looking for a quality cruise at a realistic price.

PRE AND POST CRUISE TOURS are available to Denali National Park aboard the McKinley Explorer, Fairbanks, the Canadian Rockies, Seattle, Vancouver, Anchorage and the Arctic Circle.

INCLUDED FEATURES Round trip jet air transportation by scheduled air service, seven days cruising on board the deluxe cruise liner *mv Horizon*, eight meals per day, and much, much more.

AVAILABLE TO MEMBERS, THEIR FAMILIES AND FRIENDS.

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Physicians Seize the Reins of Change

Proposed Physician Services Organization Takes Shape

ALTERNATIVES FOR ISMS PSO CORPORATE STRUCTURE UNDER STUDY

Following approval of the *Conceptual Business Plan* for a physician services organization (PSO) by the ISMS Board of Trustees in September, an intense planning effort has begun to further define the PSO business organization.

Questions that will prove to be critical to the ISMS PSO (formerly known as MSO), ranging from corporate structure and governance to site of business registration, are being carefully researched and analyzed. Interviews with prospective investment experts are underway and alternative financing opportunities are being explored.

BETA SITE SELECTION TO BEGIN

Careful testing and refinement of the PSO's consulting services, information management systems and other products will be critical to the PSO implementation process. Testing will be conducted using at least two demonstration or "beta" sites.

Practices that participate as beta sites will receive state-of-the-art advice and assistance. A number of physician groups and organizations have already contacted ISMS to express their interest in serving as beta sites. ISMS is grateful for this important vote of confidence in the PSO initiative.

Beta sites will be selected using general criteria approved by the ISMS Board of Trustees in September, 1995 and specific criteria dictated by the products and services to be tested.

As agreed by the Board, at least one beta site will be downstate and one will be in the Chicago metropolitan area. To assure that beta sites are representative of ISMS members' needs and concerns, substantial ISMS membership—at least one half of the physicians involved in the beta site—will be required. In addition, beta site participants will be expected to concur with the underlying philosophy of the ISMS PSO and its commitment to physician leadership.

Beta sites may be entirely physician-owned or in the process of retooling for physician control.

Further, while beta sites will be subsidized to some extent due to their experimental nature, there must be a substantial financial commitment to share costs by the participating physician organization, including a willingness to contribute capital to drive the initiative.

To test the efficacy of the PSO's consulting capacity, a "development" beta site will be sought. A development site will involve a group

of physicians that intends to establish a formal operating and management organization, but has not yet done so. Guidelines for selection of a development beta site specify that there be local physician leadership with a core of committed physicians, including primary care physicians.

The optimal developmental services test site will be one in which a productive organizational structure is lacking and the group reflects ISMS members' needs and concerns. In addition, the physicians involved in the group must have credibility and presence in their local medical community and there must be some demonstration of likely payer interest in contractual relationships with the proposed physician organization.

To test the ISMS PSO's information systems capacity, a physician organization that has already established itself as a legal entity, has developed bylaws, has an appointed or an elected board and whose membership includes a strong primary care base will be sought. The optimal information systems beta site will have strong and able physician leadership, presence and credibility in the medical community and either experience with capitation or known potential for immediate payer interest.

For more information or to find out how your group might apply to be a test site, please contact 1-800-782-4767.

ELSEWHERE IN THE UNITED STATES...

Across the country, state medical societies are exploring opportunities to establish physician-driven managed care systems. Like ISMS, several state societies have already implemented, or are about to implement, exciting new member service initiatives.

An inventory of state activity prepared by the American Medical Association (November, 1995) indicates that a growing number of state societies are implementing physician-first strategies.

Early state medical society efforts appear to have focused on formation of competitive contracting networks, primarily through independent practice associations (IPA). ISMS carefully studied this option in its 1994 feasibility analysis. The strategy was rejected, largely because many of Illinois' medical markets were already well "saturated" with IPA products.

More recently, state medical society attention has turned to meeting members' needs for fundamental management support services, services that enable them to form their own, tailor-made, physician-driven networks and managed care contracting organizations.

Most state medical societies that offer management services organizations and physician contracting networks have established these organizations as for-profit subsidiaries of the society, funded by the capital contributions of members through the sale of stock. More than 1,878 Kansas physicians, for example, have committed \$7.3 million in capital to support the Kansas Medical Society Physician Organization network called the Heartland Health Network, Inc.

The Pennsylvania Medical Society established a for-profit subsidiary in April, 1994. Called PennMed Member Services Company (PMSCO), it provides consulting services to physicians and health care organizations, helping them to establish more effective relationships with managed care organizations, hospitals, and others. PMSCO also offers an administrative services organization that provides services such as claims processing, utilization review, credentialing and quality assurance.

The Washington State Medical Association has formed a physician-directed health plan, Unified Physicians of Washington (UPW). Under UPW, care is delivered through local groups of physicians with administrative support coming from the corporation. UPW raised \$4.8 million from 1,644 physician investors in its initial stock offering last year. A second offering is underway to raise another \$2-\$5 million.

REGIONAL WORKSHOPS FOR PHYSICIAN LEADERSHIP

The Illinois State Medical Society is hosting six regional workshops to assist members interested in exploring opportunities to build physician-driven managed care organizations. Workshops will provide in-depth discussions of the skills and management tools needed by practices of all sizes and types—solo practice, small group or large group practices, single and multi-specialty groups, to compete successfully in the markets that are increasingly being dominated by managed care contracting.

Each session will be led by an ISMS District Trustee and will feature expert panel members who will share their experiences in forming physician-driven managed care organizations. Information about the proposed ISMS PSO will be provided. There will be some variation among the workshops, due to speaker availability and local concerns.

There is no charge for this important opportunity. All members are encouraged to attend! For registration materials or additional information, call 1-800-782-4767 today. A "working" dinner will be provided.

Peoria
January 17, 1996
5:00- 9:00 p.m.
Holiday Inn Centre
500 Hamilton Boulevard

Springfield
January 18, 1996
5:00 - 9:00 p.m.
Renaissance Springfield Hotel
701 East Adams

Chicago
January 20, 1996
Chicago Medical Society
Midwest Clinical Conference
(conference registration fee required)
8:00 - noon
Sheraton Chicago Hotel and Towers
301 East North Water Street

Champaign
January 24, 1996
5:00 - 9:00 p.m.
Jumer's Chateau
1601 Jumer Drive

Rockford
February 7, 1996
5:00 - 9:00 p.m.
Clock Tower Inn
7801 East State Street

Carbondale
February 8, 1996
5:00 - 9:00 p.m.
Holiday Inn- SIU
800 East Main Street

Collinsville
February 15, 1996
5:00 - 9:00 p.m.
Holiday Inn
1000 Eastport Plaza Drive

ISMS designates this continuing medical education activity for 3.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

The Illinois State Medical Society is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Workshop participants will learn how to:

1. Identify local and national managed care initiatives and trends;
2. Define the characteristics of a local physician-driven organization;
3. Describe the key components required to successfully manage the capitation business enterprise;
4. Describe the process and techniques used to effectively plan for and implement physician-driven entities; and
5. Describe and discuss the ISMS PSO business planning process.



For sale: Calyx MDX system software program with all latest updates included. Complete billing and insurance system – \$3,000, firm. Please send responses to P.O. Box 483, Edwardsville, IL 62025.

Chicago, near Edgewater Hospital: 3,100-square-foot medical building. Four suites, X-ray rooms, separate HVAC. Steal for \$139,500. Call Mr. Goldberg, Hallmark & Johnson, (312) 465-8000, ext. 29.

College Drive: Physician office space available in Palos Heights for sublease. Three exam rooms, spacious waiting room. Available three days a week. For more information, call Julie at (708) 361-0730.

Near 26th and Pulaski in thriving Hispanic neighborhood. Two large units available in busy dental practice building. Reasonable rent, indoor parking available. (312) 522-5011 or (312) 495-0050.

Elgin. Medical space available in fast-expanding area, time-share available. Fox Valley Medical Center on six acres with ample parking lot. (708) 697-7870.

Will be available for rent. Location! Location! Location! Surgical and medical specialists' center, 8425 South Cottage Grove in Chatham. Brand-new medical office building – 900-square-foot office with five rooms, including a treatment room, storeroom, private washroom, receptionist's room (also a general lobby, public washroom and drinking fountain). Suitable for any specialty. Call (312) 723-3300.

Fox Valley medical office for sale in fast growing Kane County (west of Chicago). Services Geneva, Batavia and St. Charles, population of about 75,000, 10 minutes from I-88, also near Elgin and Aurora. Also available, X-ray, furniture and personnel from existing surgical and family practices. Call Joan, (708) 232-1500.

Opening a new practice or expanding? Discover our used-equipment showroom, where you can save on high-quality trade-ins and/or new equipment. Fast delivery from our large inventory. Exam tables, electrocardiograph, stress, autoclaves, microscopes, holter, ultrasound, surgery tables, surgery lights, bovie, laparoscopes, etc. New distributors of Burdick, Welch-Allyn, Tycos, Ritter, Miltex, Pelton-Crane and Baum. Call Robert Shapiro, Combined Medical, 3433 W. Peterson Ave., Chicago, IL 60659; (312) 588-8111.

Viewboxes for sale: Two sets of six viewboxes with bottom row angled for desk work, hot light. Will deliver, \$650 or best offer. (312) 337-8915.

Jamaica villa in Silver Sands private international beach-club community halfway between Montego Bay and Ocho Rios. Our luxury villa has a large swimming pool, four bed/bath suites. Daily cook and maid furnished. Ideal for families or friends vacationing together. Tranquility assured. \$2,500-\$3,300, winter season; \$1,800-\$2,200 per week from 4/15/96. (800) 260-1120.

East Dundee medical office to share/sublease, fully furnished, new build-out in free-standing building, easy access from I-90, near major area hospitals, spacious parking. Call (708) 622-1212.

Miscellaneous

March 16: "Current Clinical Challenges with Difficult-to-Treat Psychiatric Disorders," featuring Glen Gabbard, MD; John H. Greist, MD; Del Miller, PharmD, MD; and Mauricio Tohen, MD, DrPh. Location: The Ritz-Carlton, Kansas City, Mo. CE credit: 5 hours. Cost: \$75. Contact Menninger Continuing Education, (800) 288-7377.

Electronic medical billing services: Full-service medical billing and consulting providing comprehensive, confidential help to increase and maximize your cash flow while reducing administrative headaches. Contact Mid-America Medical, 3000 Dundee, Suite 411, Northbrook, IL 60062; (708) 272-7272.

IM board review course: Personal attention, small group: St. Louis, 4/10 to 4/14/96; Newark, N.J., 6/26 to 6/30/96. Full course in video also available. Call (800) 97-IMBRC (46272). Write to IMBRC, 5892 Whitestone Drive, Columbus, OH 43228.

Transcription service: 8.5 cents per line (based on volume), phone-in dictation, modem, messenger service, 24-hour service. Excellent references. Lee-Perfect Transcribing, (312) 664-1877.

Want to increase your patient base? We can get it done! If you are interested in building your practice by marketing to patients, increasing your referral base or participating in managed care networks, then let us help you. Target Market Communications Inc. specializes in marketing for health care providers. We are experienced in developing and implementing marketing programs for office-based physicians, hospitals, managed care providers and medical technology facilities. For a consultation on how to achieve your marketing objectives, call Mary Benson at (708) 747-7701.

Physician Financial Services will tackle all your medical billing needs. Are you collecting what you did two to three years ago? We specialize in software with built-in edits, meaning fewer errors, thereby more money. Updated CPT and ICD-9 codes. Take care of more patients. We'll handle the paperwork. Free computer demonstration and information. Call (312) 391-9183 or write to MBC of Chicago/Lincoln Park, 2424 N. Clark, Suite 620, Chicago, IL 60614.

Medical CD-ROMs/software: Free catalog. More than 150 Macintosh and IBM titles. Guidelines and technical information included. Discounted and bundle prices. Call IMG Inc., (800) 571-5444.

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Physicians merge

(Continued from page 1)

and has been operating since Oct. 1, according to Dr. Dan. In developing protocols and clinical pathways for the new group, member physicians share information about treatments and techniques that each has used successfully. Dr. Dan said each of the 23 practices has brought good ideas to the group. "Hopefully, the sum total of those will be better than the individual units."

The group has created a board of directors plus separate committees that deal with utilization and quality assurance, contracting and marketing, credentialing, provider compensation and logistical issues such as the number of office locations

and ways to standardize procedures. The committees meet about once a month, while the entire group convenes quarterly to discuss where the practice is going and what issues group members want to work on, Webb said. Scheduled for this month's group meeting, for example, were an AMA representative to discuss coding and a pension adviser to address financial issues. "A private practice couldn't afford these kinds of things, but the educational things are built into the structure of this organization," Webb said.

"I was one of four doctors in a practice, and we never would have had the time, resources or ability to do this kind of thing on our own," Dr. Dan said. "And frankly I don't think payers would have been interested. Payers are more interested in large groups that show a commitment to [activities] like utilization review and quality assurance."

"There is a lot of pressure on insur-

ance companies," Webb said. "They need ways to economize, and it's easier to sign up 63 doctors in one stop than it is to sign up 63 doctors individually."

Although Mid-America Medical Group consists of primary care physicians, specialists will play an important role. The primary care doctors in each area will decide which specialists they want to work with "based on [the specialists'] clinical credentials plus a long-standing reputation of working collaboratively with primary care doctors," Webb explained. In addition, specialists interested in working with the group must agree to sit on its medical policy committee to develop care pathways and protocols in their respective specialties. "Preferences will be given to those who will accept risk and capitation on the

same basis as the primary care doctors," Webb said.

The group is prepared to offer capitated contracts, even though managed care has not yet established a foothold in DuPage County, Webb noted. "The doctors are now paid based on collections minus overhead. But when we get to managed care, they'll be paid on a per-patient, per-month basis," he said. The physicians will also share in risk pools for specialists and within the year plan to share with area hospitals savings achieved through utilization management and preventive medicine.

Down the road, Mid-America Medical Group plans to offer preventive care services. "For example, we might send a team out to the homes of the frail elderly to look for things that might cause them to trip," Webb said. "We'll build stands with side rails so they can do the dishes and not fall and break a hip. And there will be a system in place that will tell if

DEAN DEVERT, a field representative in ISMS' division of governmental affairs, is the most recent recipient of the Society's Employee Recognition Award. In nominating him, a physician cited Devert's accessibility, promptness and willingness to help physicians achieve the goal of providing quality care to patients.



Andrew Corrigan-Halpern

The group is prepared to offer capitated contracts, even though managed care has not yet established a foothold in DuPage County.

kids haven't been in for their immunizations or if a woman has missed a mammogram or Pap smear. But until we get [capitated], we won't have the resources to do these things."

Webb said neither he nor the physicians "are looking through rose-colored glasses," yet they are confident the integrated group will succeed in an increasingly managed care environment. "We have been in a managed cost and not a managed care environment. And managed cost means deeper discounts and doctors having to work harder to make the same amount of money," Webb said. "True managed care is asking, 'How is it that I can keep these patients as well as possible for as little cost as possible and also motivate them to get involved in their own care?'"

"Though this is not the only model, I think it will work for us," Dr. Dan said. "With other models like IPAs [independent practice associations] there is more of a tendency to say, 'I'll get what I can out of the IPA,' instead of saying, 'This IPA is my practice.' But I have the conviction that this makes us interdepen-

dent. We will be sure each of us makes the educational and behavioral changes we need to make. This group is my practice, and it has to work."

To support ISMS members who want to develop physician-driven managed care organizations or maintain their clinical independence regardless of their practice structure, the Society has proposed the Physician Services Organization. The entity would provide support through a range of consulting, practice management and information systems services. The ISMS Board of Trustees approved the conceptual business plan for the PSO in the fall of 1995. ■

DOI drops

(Continued from page 1)

number of claims filed by patients on nonstandardized forms, Kotowski said.

"I think the DOI rightly responded to the concerns of ISMS and others who expressed concerns," Dr. Welch said. "The whole idea of the uniform billing act was to make it easier [to file claims]. But rather than simplifying the process, [the amendment] was making it more complicated."

ISMS House of Delegates policy advocates the use of the 1500 claim form by all insurance carriers and physicians but only when insurers are being billed directly. "The problem was that when people were paying their bills over-the-counter, the forms still would have been required. I think the Department of Insurance recognized that that was unworkable in doctors' offices," Dr. Welch said.

The new law and subsequent rules eliminate the use of "superbills" for billing purposes but will not affect physician offices that submit claims to payers electronically, an ISMS analyst said. ■

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OBITUARIES

*Indicates member of ISMS Fifty Year Club

*Ballinger

Charles S. Ballinger, MD, a general surgeon from Cumberland Foreside, Maine (formerly of Rockford), died Aug. 29, 1995, at the age of 74. Dr. Ballinger was a 1944 graduate of Harvard Medical School.

*Crystal

Harry M. Crystal, MD, an internist from Chicago, died Aug. 17, 1995, at the age of 87. Dr. Crystal was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

*DuPuy

E. Newton DuPuy, MD, an Ob/Gyn from Spring Green, Wis. (formerly of Quincy), died Sept. 7, 1995, at the age of 90. Dr. DuPuy was a 1932 graduate of Duke University School of Medicine, Durham, N.C.

Epsteen

Casper M. Epsteen, MD, a plastic surgeon from Chicago, died Aug. 19, 1995, at the age of 93. Dr. Epsteen was a 1926 graduate of the University of Illinois College of Medicine, Chicago.

*Geiger

Clyde J. Geiger, MD, an Ob/Gyn from Winnetka, died Sept. 11, 1995, at the age of 93. Dr. Geiger was a 1928 graduate of Northwestern University Medical School.

*Gianturco

Cesare Gianturco, MD, a diagnostic radiologist from Savoy, died Aug. 25, 1995, at the age of 90. Dr. Gianturco was a 1927 graduate of Facolta di Medicina e Chirurgia dell'Universita di Napoli, Napoli, Italy.

*Greider

Jack L. Greider, MD, a general practitioner from Decatur, died Oct. 11, 1995, at the age of 74. Dr. Greider was a 1945 graduate of the Medical College of Wisconsin, Milwaukee.

Kheradyar

Nejat Kheradyar, MD, an Ob/Gyn from Skokie, died Oct. 5, 1995, at the age of 59. Dr. Kheradyar was a 1962 graduate of Faculty of Medicine, Shiraz, Iran.

*Koppelaar

Eliz T. Koppelaar, MD, a family physician from Lombard, died Aug. 20, 1995, at the age of 99. Dr. Koppelaar was a 1924 graduate of Washington University School of Medicine, St. Louis.

Larson

Norman E. Larson, MD, a general surgeon from Glenview, died Sept. 2, 1995, at the age of 67. Dr. Larson was a 1953 graduate of Northwestern University Medical School.

Limosani

Michael A. Limosani, MD, a pediatrician from Chicago, died Aug. 18, 1995, at the age of 74. Dr. Limosani was a 1946 graduate of the Chicago Medical School.

*Marcus-Rottman

Marion E. Marcus-Rottman, MD, a general practitioner from Chicago, died Oct. 10, 1995, at the age of 93. Dr. Marcus-Rottman was a 1926 graduate of the Chicago Medical School.

*Mulcahy

John P. Mulcahy, MD, an ophthalmologist from Scottsdale, Ariz. (formerly of Oak Lawn), died Sept. 22, 1995, at the age of 93. Dr. Mulcahy was a 1925 graduate of the University of Illinois College of Medicine, Chicago.

*Nellins

Donald C. Nellins, MD, an internist from Waukegan, died Oct. 6, 1995, at the age of 80. Dr. Nellins was a 1941 graduate of Case Western Reserve University School of Medicine, Cleveland.

*Paull

Murry M. Paull, MD, an occupational medicine physician from Chicago, died Sept. 25, 1995, at the age of 88. Dr. Paull was a 1936 graduate of the Chicago Medical School.

*Randolph

Theron G. Randolph, MD, an allergist from Batavia, died Sept. 29, 1995, at the age of 89. Dr. Randolph was a 1933 graduate of the University of Michigan Medical School, Ann Arbor, Mich.

Reinwein

William D. Reinwein, MD, an orthopedic surgeon from Moline, died Aug. 15, 1995, at the age of 71. Dr. Reinwein was a 1950 graduate of Facolta di Medicina e Chirurgia dell'Universita di Roma, Roma, Italy.

Rosner

Marvin A. Rosner, MD, an Ob/Gyn from Chicago, died Oct. 15, 1995, at the age of 71. Dr. Rosner was a 1946 graduate of the University of Illinois College of Medicine, Chicago.

*Sanders

Maude A. Sanders, MD, a general practitioner from East Peoria, died Oct. 14, 1995, at the age of 88. Dr. Sanders was a 1939 graduate of Meharry Medical College School of Medicine, Nashville, Tenn.

IDPR DISCIPLINES

This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

March 1995

Veljko Corak, Northfield – physician and surgeon license indefinitely suspended after submitting claims for medical services provided to numerous patients while license to practice medicine was in a nonrenewed status.

Ian Andrew Kling, Kirksville, Mo. – physician and surgeon license reprimanded after being disciplined in the state of Missouri.

Ricardo Lopez, Metairie, La. – physician and surgeon license indefinitely suspended after being disciplined in the state of Louisiana.

Wes McRae, Chicago – physician and surgeon license reprimanded after being disciplined in the state of Michigan.

Thomas E. Porter, Goreville – physician and surgeon license placed on probation for two years and controlled substance license suspended for one year followed by two-year probation after allegedly nontherapeutically prescribing controlled substances and being terminated from the Public Aid Vendor program.

Subarna P. Pradhan, Franklin Park – physician and surgeon license reprimanded and fined \$1,400 after practicing on a nonrenewed license.

William Roggenkamp, Lemont – physician and surgeon license reprimanded and fined \$2,600 after practicing on a nonrenewed license.

James A. Runke, Barrington – physician and surgeon license reprimanded and fined \$2,300 after practicing on a nonrenewed license.

Richard Y. Saffir, New Orleans – physician and surgeon license placed on probation for five years after allegedly being disciplined in the state of Louisiana.

Prithviraj S. Thakur, East St. Louis – physician and surgeon license reprimanded and fined \$2,000 after practicing on a nonrenewed license.

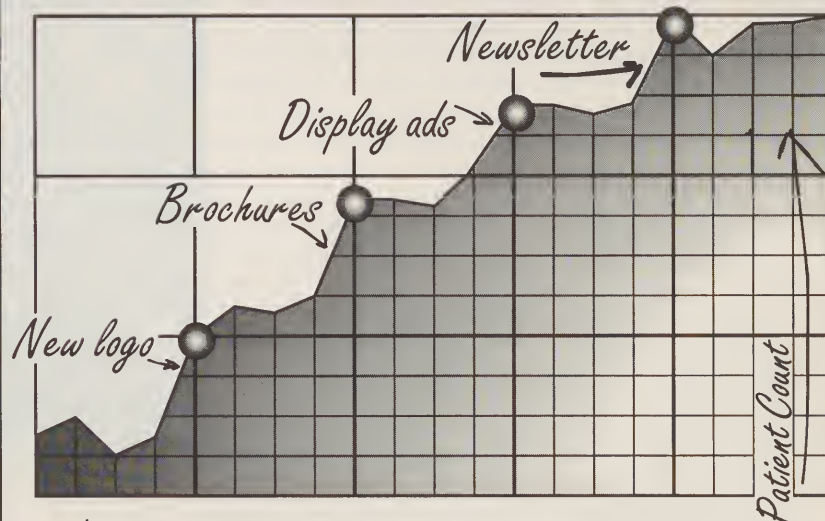
April 1995

James H. Desnick, Highland Park – physician and surgeon license placed on probation for five years and, as a condition of probation, will not practice medicine in Illinois for two years and fined \$100,000 after allegedly violating provisions of the Illinois Medical Practice Act.

Joseph Delucia, West Plains, Mo. – physician and surgeon license and controlled substance license placed on probation until July 15, 2001, after being disciplined in the state of Missouri.

Wilbur Johnson, Hanover – physician and surgeon license placed on indefinite probation due to alleged chronic and acute ethanol alcoholism.

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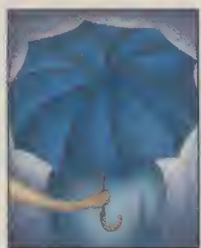
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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • FEBRUARY 2 1996

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Edgar proposes consolidating seven state agencies into one new department

ADDRESS: Establishing the Human Services Department would streamline the delivery of services.

BY MARY NOLAN

[SPRINGFIELD] In his Jan. 10 state of the state address, Gov. Jim Edgar proposed reducing the number of cabinet-level agencies by seven and establishing one agency – the Department of Human Services – to decrease administrative overhead and improve the delivery of services. The new department would consolidate programs that are currently coordinated by the departments of Public Aid, Alcoholism and Substance Abuse, Public Health, Aging, Children and Family Services, Mental Health and Developmental Disabilities, and Rehabilitation Services. In addition, other smaller agencies may be consolidated, according to background papers from the governor's office.

Under the current system, the separate departments each have "their own personnel offices, their own legal staffs, their own communications offices and their own programs," Edgar

noted. "We cannot afford to tackle the significant challenges we face with separate and overlapping bureaucracies and services that sometimes duplicate each other."

Streamlining the seven agencies would reduce bureaucracy, Edgar said. The move also would enable Illinois to take full advantage of the greater flexibility Congress is expected to grant states in using federal dollars, he said.

Reactions from officials at the departments of Mental Health and Developmental Disabilities, Public Aid and Public Health were positive.

According to John Lumpkin, MD, director of the Illinois Department of Public Health, Edgar's proposal will improve interactions between physicians and human service agencies. Noting that IDPH provides numerous services for pregnant women and infants that are also offered by the public aid and



Edgar

Ron Ackerman

reduced under the governor's proposed reorganization, said Ann Patla, director of the Illinois Department of Mental Health and Developmental Disabilities. In addition, "the reorganization would allow for a more naturally coordinated system of care that would result in easier access for people."

"Gov. Edgar expects all the departmental directors to meet with him to help with the implementation of the consolidation of the state's human services," Patla said.

As outlined in the background papers, Edgar's proposed reorganization will develop a common intake and tracking system, define common boundaries for service delivery regions, combine programs currently spread over two or more agencies and focus on particular problem areas.

The administration plans to convene a series of focus groups and other forums to address reorganization, according to the background papers. After evaluating that information, Edgar will present his reorganization plan as an Executive Order by April 1.

children and family services agencies, Dr. Lumpkin said, "For too long, the services in Illinois have been fragmented and compartmentalized. Restructuring will create an environment where service-coordination becomes the norm rather than the exception."

Service duplication is a problem, agreed Dean Schott, a spokesperson for the Illinois Department of Public Aid. "At this point, there are instances where an individual has to contact three different agencies to receive the same care. We should be making it easier for people to receive services that they're eligible for."

Such redundancies would be

ISMS, MBGH sponsor symposium on employer-provider partnerships

MANAGED CARE: Program focuses on collaboration and contracting.

BY MARY NOLAN

[CHICAGO] Physicians and employers can work together effectively to manage the changing health care environment. That was the theme of "Health Reform at the Community Level," an employer-provider symposium sponsored by ISMS and the Midwest Business Group on Health and held last fall at the Westin Hotel in Chicago. Nearly 200 physicians, employers, speakers, sponsors and exhibitors attended the program, which enabled participants to exchange ideas on providing quality, cost-efficient care in small and medium-size communities.



Dr. Ruecker

John McNulty

The symposium covered such specific topics as contracting issues for physicians, hospital mergers, data management and the formation of partnerships between employers and providers.

Employer-provider partnerships are being formed across the country, significantly changing the health care delivery system, said ISMS President Raymond Hoffmann, MD. "Employers need to make cost-effective, high-quality medical care available. Physicians are ready, willing and able to provide it. However, to successfully do so, physicians must remain in charge of clinical decision-making."

"Many of us have awakened to a new national order for health care delivery," said ISMS Seventh District trustee Ronald Ruecker, MD, a Decatur gastroenterologist. "To succeed in that new order, a new breed of physicians will be essential – those

(Continued on page 14)

IDPH appoints members to Violence Prevention Authority

SELECTION: Director chooses ISMS' president-elect.

BY KATHLEEN FURORE

[SPRINGFIELD] Director of the Illinois Department of Public Health, John Lumpkin, MD, appointed ISMS' President-elect Sandra Olson, MD, to the Illinois Violence Prevention

Authority in mid-December 1995. The authority was created by legislation Gov. Jim Edgar signed last August and was organized to develop a

(Continued on page 15)

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Physicians needed for Illinois Medicare PRO positions

RECRUITING: Search underway for medical director, principal clinical coordinator. BY KATHLEEN FUREORE

[CHICAGO] Contingent on obtaining a successful bid for Illinois' Medicare peer review organization contract, ISMS is seeking candidates to apply for two positions within the PRO to help evaluate study outcomes. Last fall, ISMS joined KePRO, a wholly owned affiliate of the Pennsylvania Medical Society, in bidding for that contract.

The studies will focus on improving care through quality improvement projects, rather than individual case review, reflecting expected changes in the requirements of the U.S. Health Care Financing Administration. Although HCFA will still require some individual case review, that will likely represent only 2 percent of Medicare discharges, rather than the 18 percent sampling and review of discharges that had been

required in the past, said Ronald G. Welch, MD, chairman of ISMS' Board of Trustees, in a recent letter to county medical society leaders.

The first PRO position is for a full-time principal clinical coordinator who will be based in the Chicago area. The coordinator will be responsible for health care quality improvement efforts involving physicians, hospitals and managed care plans. Duties will include working with PRO staff, health care providers, professional societies and consumer groups to convene meetings and study groups relevant to HCFA-directed and PRO-initiated cooperative projects.

Physicians applying for the coordinator position must be licensed in Illinois, understand statistical analysis and be

knowledgeable in epidemiology and current clinical research and practice guidelines. Applicants should have experience in public speaking, clinical practice and outcomes data analysis, and direction of other health care professionals.

The part-time medical director will supervise all activities relating to physician review. Responsibilities will include analyzing the results of utilization denials, confirmed quality concerns and sanction recommendations. In addition, the director will help communicate review results to the medical community; work with the physician clinical coordinator to develop health care quality improvement initiatives; recruit, train, develop and support associate medical directors; and serve as a liaison to HCFA and the physician and provider communities.

Applicants must be board-certified MDs or DOs licensed in Illinois. Requirements include 10 or more years of combined training and experience in medical care quality review and/or utilization review and experience with executive medicine. Prior management and PRO experience are preferred.

Interested physicians should call ISMS at (312) 782-1654 or (800) 782-ISMS. ■

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Market STATS

City hospitals more expensive than suburban

For many of the most common illnesses, it's more expensive to receive treatment in a Chicago city hospital than in a suburban hospital, according to comparisons of data gathered by the Illinois Health Care Cost Containment Council. For both city and suburban hospitals, the No. 1 reason for hospitalization (excluding childbirth) for people under age 65 was psychosis. However, in this category, the average charge and length of stay in city hospitals was \$12,158 for 13.9 days, compared with \$11,683 for 12.1 days in suburban hospitals.

Crain's Chicago Business
Dec. 11, 1995

Physician network to span 19 states

The acquisition of Pacific Physician Services Inc., based in Redlands, Calif., by Medpartners/Mullikin Inc. has created the immediate potential for a network of 4,800 physicians in 19 states. Medpartners/Mullikin, based in Birmingham, Ala., acquired the California network in December 1995 with a tax-free stock transaction worth about \$332 million. The merged company will market low-cost health services to HMOs and insurance company health plans.

New York Times
Dec. 14, 1995

Census yardstick measures boom in health businesses

A comparison of the 1987 and 1992 economic censuses shows that in 263 of 298 ranked metropolitan areas, the number of health-related businesses increased. The biggest booms occurred in Florida's retirement areas. The greatest drop was in the LaCrosse, Wisconsin-Minnesota metro area, which lost 15 percent of its 143 health businesses.

American Demographics
November 1995

Ten Canadian physicians go the dial-a-doc route

Ten family physicians in the Canadian province of New Brunswick are helping patients' fingers do the walking. The physicians have established a 900-number medical service so that people can ask basic questions about health. The cost is \$2.95 per minute, with a maximum of \$37 for long calls. The doctors don't prescribe medications or refer people to specialists over the phone.

New York Times
Dec. 14, 1995

One-third of young physicians wouldn't do it again

Would they become physicians if they had it to do over again? California Physician magazine posed this and other questions to the 4,800 members of the California Medical Association who are under 40 years old. Nearly one-third (31.4 percent) of the 1,141 physicians who filled out the questionnaire said they would not choose to become a physician if making a career decision today.

California Physician
December 1995

Lower health costs cause dip in total benefit costs

Employers' total benefit costs, which have been rising for decades, have now taken a dip. The credit goes to reduce health care costs. The U.S. Chamber of Commerce says total benefit costs fell from an average of \$14,807 per employee in 1993 to \$14,678 in 1994, a decline of 0.8 percent. It was the first decline in the nearly 50 years the Chamber has been tracking such costs. The cost of health care, which was the main reason overall benefit costs rose for decades, was also the main reason they fell in '94. The average cost of a medical plan per employee dropped from \$2,851 in 1993 to \$2,579 in 1994, a 9.5 percent decline.

Business Insurance
Dec. 4, 1995

Team trauma effort helps victims of Fox River Grove bus-train wreck

EMERGENCY CARE: Procedures ensure communities are covered when an accident occurs. BY KATHLEEN FUREORE

[MCHENRY] Minutes after a train and school bus collided in Fox River Grove last fall, paramedics arrived to help young victims at the scene. But it took the intricately coordinated efforts of paramedics, physicians, hospitals, nurses, fire departments, ambulance services and helicopters to assess, transport and treat those involved in the accident that killed seven teens, according to George Gallant, MD, an emergency physician at Northern Illinois Medical Center. Dr. Gallant is the project medical director for the McHenry-Western Lake County EMS and coordinates emergency medical response for that area.

The police are the first to be notified when such an accident occurs, Dr. Gallant said. "I'm sure here they were flooded with calls," he said of the accident that occurred as the bus was transporting students to school. "The rescue squad sends paramedics out to do the initial triage. They turn into a command post and do triage on the scene."

Northern Illinois Medical Center was the off-site command post, or resource hospital, that communicated with those on the scene and contacted other hospitals to determine how many victims each could handle. The staff then transmitted the information to the paramedics, who sent patients to the designated hospitals. "We always want to disseminate the reds [critically injured] and yellows [injured but stable victims] so no one hospital is totally overloaded," Dr. Gallant said.

Because the Fox River Grove accident was a severe, multiple-casualty accident, the on-site incident commander (a member of the paramedic squad) determined that it warranted several ambulances, three helicopters and a physician. Dr. Gallant was the physician who arrived at the scene. "I was home in bed when the hospital called and said they needed a doctor. When I got there, the critical patients already had been transported and the Flight for Life helicopter was lifting off. I checked the patients declared deceased

and checked the green patients – the walking wounded. But I didn't do any intubations or aggressive treatment."

Also called into action was the area's Mutual Aid Box Alarm System – a fire and rescue team charged with planning for and activating emergency resources in multiple-casualty accidents.

The team helps ensure that enough emergency help is available and that no area is left uncovered when a major incident occurs. "The concept is that if you need more equipment and manpower – say you need 10 ambulances and you have only three – others will come and help," Dr. Gallant said. Working with various fire and rescue squads, the team arranges to have backup assistance available in case one community's emergency equipment and manpower are "sucked out of the area" by one accident. "They'll get rescue squads from additional locations to handle future emergencies [that might occur simultaneously] so the community is never uncovered," he said.

Although Dr. Gallant was the physician at the scene, the paramedics and other emergency personnel are those "who need to be applauded," he noted.

"Any time a kid is involved, it hurts more," Dr. Gallant said. "This wasn't as bad for me because I didn't know the victims personally. But [members of] the local rescue squad knew virtually all these people. One-hundred percent of them knew somebody on the bus, and 95 percent knew one of the deceased."

Physicians and other emergency personnel on duty at Good Shepherd Hospital in Barrington, where 10 victims were sent, also knew many of the victims. "We're a small neighborhood hospital that's used to seeing trauma cases," said Good Shepherd spokesperson Cheryl Smith. "[But] the fact that these were friends, neighbors, young people [elicited] a different response. People were much more affected than they thought they would be." ■

Tracking the flu season

NUMBERS: IDPH, physicians have noticed some activity with the flu A virus. BY MARY NOLAN

[SPRINGFIELD] If the prevalence of sufferers who are sniffing, sneezing and coughing was the only indicator, many would consider influenza to be a statewide epidemic already this year.

Officially, however, "there's simply no way of knowing how many cases we have," said Tom Schafer, an Illinois Department of Public Health spokesperson. Unlike such illnesses as measles, influenza is not a reportable disease, he noted. "Quite simply, it's an impossible thing to keep track of."

"The only way that we can find out whether there is any flu activity is through our surveillance system," Schafer explained. Under this system, IDPH contacts a select group of physicians, hospital emergency departments and school districts throughout the state. Activity is classified as "no activity," "sporadic," "regional" or "widespread," depending on whether levels are increasing.

As of mid-January, IDPH officials classified flu activity in the state as regional for the flu A virus, Schafer reported. "That virus is common for outbreaks of influenza that occur nearly every year and is often associated with increased rates of hospitalization and death," Schafer said.

In Chicago, there had been only one confirmed case of influenza, while suburban Cook County had reported no cases, according to spokespersons from the city and county health departments.

The Chicago case involved a 2-year-old girl in the North Lawndale area on the city's West Side, according to Tim Hadac, a spokesperson for the Chicago Department of Public Health. "The child did not require hospitalization and has recovered, but because her lab tests indicated that the strain was type A flu, we have stepped up our efforts to educate and motivate people who are at risk for flu," Hadac said. The city has already given more than 44,000 free flu shots to people at 75 sites across the city, he said.

Few influenza sufferers seek treatment for their illness, however, which makes the disease even more difficult to track. "The flu is not that serious for most patients, which is one reason doctors don't see a whole lot of it," Schafer noted.

IDPH laboratories generally receive 50 to 100 throat cultures every year from physicians, who submit them voluntarily after test results indicate their patients have influenza. About 20 had been submitted by the second week of January, Schafer said.

What physicians and public health officials have noticed is that the vaccine developed to combat this year's expected strain of flu has been on target, according to Charles Jennings, IDPH public health program administrator. "So far we're seeing the H1 N1 strain, which is a component of this year's vaccine," Jennings noted.

Furthermore, while public health officials generally suggest that people receive the vaccine in the fall – before flu activity levels rise – physicians should be aware that they can still give the vaccine to their patients in some cases, Jennings said.

"It's not effective in individuals within 24 hours of their being exposed to the type A flu, but in a controlled environment, such as a nursing home, it can be effective if the virus hasn't been brought into the environment yet," he said. Physicians also need to remember that it takes two weeks for immunity to build up after the vaccine is administered, he cautioned.

Physicians and other health care pro-

fessionals should also be vaccinated if they haven't been already, suggested Donald Graham, MD, an infectious disease physician at Springfield Clinic.

The next line of defense against flu A consists of the anti-viral medications amantadine and imantadine, Dr. Graham said. "They're both widely used, but they need to be given within 48 hours of the onset of symptoms to be effective," he warned. Side effects may include urinary retention in many, dry mouth and, in the elderly, some confusion, he noted. "Sometimes a lower dosage is necessary for the elderly and children."



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REPORT FOR ILLINOIS PHYSICIANS

OPTIMIZING LENGTH OF STAY FOR CEREBRO VASCULAR ACCIDENT (CVA)

In recent years, physicians have greatly improved the treatment of hypertension, with both aggressive pharmacologic and non-pharmacologic approaches. Furthermore, the general public has become increasingly aware of the desirability of tight control of hypertension. In spite of these advances, cerebro-vascular accidents (CVA's), although reduced in over-all incidence, are still a common cause for hospitalization.

The key factors for optimizing an in-patient stay for CVA patients include:

- an aggressive assessment for severity, and an early work-up for etiology
- prompt stabilization of the patient's neurological and general clinical status by close observation and tight management
- initiation of the discharge planning process within 24 hours of admission
- an early assessment of patients with significant functional disability and impairment by a physiatrist or a physician trained and experienced in acute rehabilitation medicine (could be done within the first 24-48 hrs in some patients)

For most patients with an embolic or thrombotic CVA, clinical and neurological stability can be attained within three days of hospitalization. It should then be the intent to transfer the patient to a less acute setting.¹ Depending on the functional disability and impairment of the patient and other factors such as mental status, home environment and associated medical conditions, the patient could receive further care in one of the following settings:

- Home
- Acute rehab unit
- Sub-acute unit
- Skilled Nursing Facility
- Nursing home

Thus, the optimum length of stay (LOS) of three days for many CVA patients could be achieved by early assessment, efficient work up, aggressive clinical and neurological management, prompt discharge planning, and evaluation for further care in a less acute setting.

¹ A model for management of patients with stroke during the acute phase. Outcome and Economic implications. Stroke 1993 Dec; 24 (12): 1823-7.

² Gladman J. et al.; Cost comparison of domiciliary and hospital based stroke rehabilitation. Domino Study Group. Age & Ageing 23 (3): 241-5, 1994 May.

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EDITORIAL

It's a Darwinian world

This is a Darwinian world," said the CEO of a managed care company in the Jan. 22 issue of Time magazine. The species that prompted his remark were not plants or animals, but the proliferating managed care entities that are changing the medical marketplace.

By now, many physicians have seen that Time cover, showing a physician wearing a surgical mask as a gag. The related story discusses the case of a patient in Northern California and her protracted struggle to obtain coverage from her HMO for an autologous bone marrow transplant as treatment for breast cancer. Although the patient eventually underwent the procedure, she ultimately died. The plan administrators said her death proved the treatment wasn't in her best interest, but the patient's husband said the transplant extended her life and improved its quality.

This tragic story raises several concerns. First, it portrays the physician-patient relationship as having been irreparably damaged by managed care, with physicians being under the thumb of managed care plans. Although there are new challenges to the physician-patient relationship, physicians consider that relationship inviolable. In fact, it was a physician – the division chief of oncology at UCLA – who decided that UCLA would pay for the patient's transplant after her insurer refused.

A point that wasn't really developed

in the article was that patients need education about reviewing plans carefully before signing up for them. The patient's husband said the couple chose a plan that was the least expensive of three options. "They paid little attention to the nitty-gritty details of the plan," the story said. In fact, they didn't even obtain a copy of the complete contract until well after they had signed it. And when it arrived, the husband "threw it in a pile" of other papers. Yet bone marrow transplants as a treatment for breast cancer were excluded under the investigational clause of her contract.

Before they enroll in a plan, consumers must evaluate their coverage choices and weigh the cost vs. the inclusiveness. This is a big change from how most Americans have looked at health care.

The story doesn't discuss the contractual obligations of physicians participating in this particular plan. Contracts can be a problem, though, especially if they include provisions like gag clauses that prohibit doctors from talking to patients about testing and treatment options that may be appropriate but aren't approved by a plan. That's why support systems like ISMS' Lawyer Referral Service are so important. To help with such issues as managed care contracts, the Society enables members to access health care attorneys by calling (800) MD-ASIST.

It's true that health care is evolving, but physicians and patients have the ability to control the direction it takes. ■

PRESIDENT'S LETTER

The court system is changing

Raymond E. Hoffmann, MD



Interested people with a problem get together and find the path that will lead to a solution.

For a long time, physicians have thought that our court system was an ineffective forum for solving medical malpractice disputes. We have spent a great deal of time trying to fix it. Our recently won victory over the plaintiff bar-sponsored opposition in the Statehouse took a great deal of time and perseverance. We worked so hard because of our conviction that there was a better way.

Physicians don't understand the adversarial approach to problem-solving. In medicine we get consultations to help us. We use that new information we've gathered, add it into our problem-solving and help the sick patient who wants to get better.

It certainly doesn't work that way in law. Instead of working together, each side hires its own experts (consultants), presents its own theory of the problem (differential diagnosis) and tries to manipulate an outside panel of people carefully chosen to be uninformed about the problem (the jury), who settle the issue.

I cannot even imagine how expensive medicine would be if that were our approach.

This last week I was invited to be a member of an advisory committee to a group – the Center for Analysis of Alternative Dispute Resolution Systems, or CAADRS – that is looking into alternative dispute resolution methods of settling court cases. The executive committee of this group is made up of lawyers and judges, including the chief judge of the 17th Circuit Court. The reason that this is happening is that the courts are running out of money and are over-run with cases. The courts realize that even they must become lean and mean, just as businesses have.

I was amazed at the information shared. The 17th Circuit Court, in the Rockford area, has become the leader in this endeavor. Apparently it has settled more cases through arbitration and mediation than other circuit courts.

Arbitration is used for smaller cases (less than \$30,000) and

mediation for the larger ones. An arbitration hearing is held before a panel of between one and three sitting judges who rule on the issues of the case. A mediation hearing is held before a lawyer who has been hired by the parties involved and who facilitates the discussion and settlement. The attorney's record for settlements is known so that the parties can select the mediator who best fits their needs.

A judge will recommend that certain cases be settled through ADR, but the parties must agree. If the settlement is unsatisfactory to either party, a small fee is charged, and the case can go to court.

What interested me was that a high proportion, more than 90 percent, of these cases have been resolved through ADR. The cases can be heard before all the discovery has been completed, and they are presented in summary, without testimony. If all the parties, including insurance company representatives – the bill payers – are present, each case takes only about three hours to hear. The savings in time and money for all parties are impressive. In our community, even the plaintiff and defense bars are reportedly willing participants. This, despite what critics would say about their self-interest in delays that increase their fees.

This scenario is beginning to resemble the practice of medicine: Interested people with a problem get together and find the path that will lead to a solution. This has worked for some medical malpractice cases and should work for more. Since these cases are settled more quickly and cheaply than court cases and disrupt a physician's schedule and emotions less, I would think that any MD would be more accepting of the consequences, including being reported to the National Practitioner Data Bank.

I find this a fascinating road to start down, with the eventual goal of changing the courts from within. With our encouragement, we may end up with a better system without having to win it by further legislative battles. ■

GUEST EDITORIAL

Laughter is the best medicine

By Tim O'Brien

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Here is an effective technique for releasing stress and maintaining perspective. Norman Cousins used it twice to overcome serious illnesses. Dr. Redford Williams, a psychiatrist at Duke University, suggests it as one of 13 effective ways to reduce chronic cynicism.

It's not a difficult procedure. It only takes a little practice to become comfortable with it. At first, it is better to use this technique alone. There are three steps to it. They are: 1) Go stand in front of a mirror, 2) Look yourself straight in the eye, 3) Now, start laughing!

Most of us take ourselves far too seriously. By learning to laugh at ourselves we "lighten up" a little. It makes life more fun. Remember several of those times in life when you provided the laughter, even if to yourself, when you were alone?

Ever wondered where the phone book went, only to find it in the freezer? I have. It must have been my wife. Yes, that's it, it was her. Or one of my two daughters, but...I was alone.

Laughing at our mishaps and foul-ups helps us keep a better perspective. It helps us realize that not everything is as serious as we sometimes make it.

Humor often allows a forum for expressing feelings, which if presented in other ways, would hurt someone. We need to be careful not to make others the butt of our jokes. However, well-timed humor, or the willingness to be the cause of humor to make a point to the observer, is effective.

Laughing strengthens our immune

system. It produces immune system-enhancing chemicals that make us more resilient to disease. Norman Cousins, in his book, "Anatomy of an Illness," describes how watching Marx Brothers movies helped him laugh his way through a life-threatening disease twice.

One of the toxic-risk factors of Type A behavior is cynicism. Left unchecked, it often deteriorates into anger and finally, aggressive behavior.

In his book "The Trusting Heart: Good News for Type A Behavior," Dr. Redford Williams recommends laughing at ourselves. We should use it as a way to see the silliness of much of what makes us angry. He suggests that we try to catch ourselves in the act of being cynical. Then he says we should look closely at the act that we have allowed to make us act cynically.

Most instances will reveal a laughably unjustified basis. Do you really believe that the pokey old man in front of you in the bank line woke up this morning and decided, "I'll just go down to the bank today and delay the people behind me?"

OK, do you want to strengthen your immune system, keep a better perspective and enjoy life more?

Then, it's back to that mirror, staring yourself straight in the eye. Think of a time or situation when Shakespeare's words, "let me play the fool," were wonderfully fulfilled by your actions. And laugh that knowing laugh that satisfies, heals and entertains. ■

Tim O'Brien is director of the Institute for Stress Management in Tallahassee, Fla.

Quotables

"Most patients ask more questions of their mechanic or the guy who puts up aluminum siding than they do of cosmetic surgeons."

— **James Baker, MD**, president of the American Society for Aesthetic Plastic Surgery, on why consumers should check out the qualifications of physicians performing cosmetic surgery, Orlando Sentinel

"In most countries, the worst is yet to come. If current smoking patterns persist, then by the time the young smokers of today reach middle or old age, there will be about 10 million deaths a year from tobacco — one death every three seconds."

— **Richard Peto**, Imperial Cancer Research Fund researcher, announcing the findings from a study of smoking mortality in developed countries, Chicago Sun-Times

"In the current debate in Congress, we are seeing some hope for a return to administering health care with the interest of the patient first and revenue second."

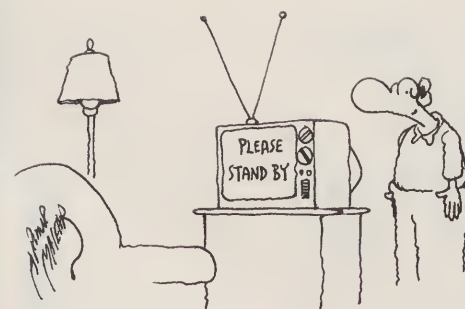
— **George M. Bohigian, MD**, on reversing the trend of seeing health care as a commodity, St. Louis Post-Dispatch

"Getting access to mental health records now is like a Hitchcockian nightmare. Everyone involved in your treatment can get them, but you can't, especially if they say it's not in your best interests."

— **Leonard S. Rubenstein**, director of the Bazelon Center for Mental Health Law in Washington, on the Medical Records Confidentiality Act pending before Congress, New York Times

"If you add something to healthy people, you have to make sure you get it right."

— **FDA Commissioner David Kessler, MD**, on the agency's upcoming decision about Procter & Gamble's request to put a fat substitute in snack foods, Bloomberg Business News



A bit on the dim side, Josh thought it was some kind of low-impact aerobics.

LETTERS

Too much political correctness

It was hard to stop from gagging while reading Dr. George Hossfeld's whining letter in your Dec. 15 edition. His self-pity seems to know no bounds. It seems what matters to Dr. Hossfeld is not the compassionate or competent work he does but what title you give him and the locale where he "specializes."

But, alas, insensitive you are not the only target of this indignation. He also whimpers about "old school" conservatives, surgeons, internists, family doctors and pediatricians.

(Only Freud could fathom why he left out obstetricians.)

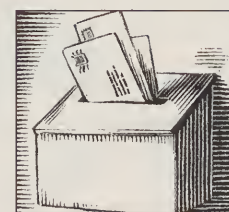
For me, I don't care what you call me, and I think there are more like me who would rather be called whatever our patients prefer than by what Dr. Hossfeld's political-correctness police require.

Well, I'm going to sit down in front of the TV on Thursday night and watch that "insensitive, dated and demeaning"

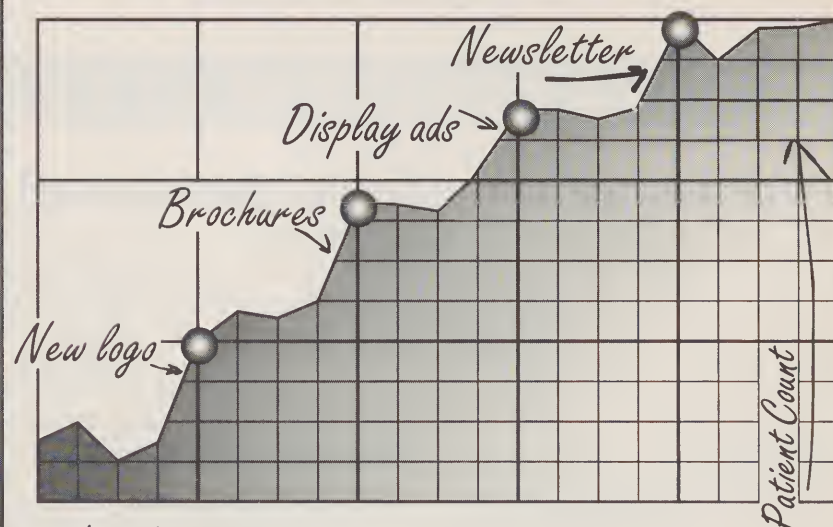
program "ER"!

— **Michael Plunkett, MD**
Chicago

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Patient Count



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ISMIE Update

Working with brokers provides another option for ISMIE policyholders

New products and services are designed to meet physicians' changing needs. BY KATHLEEN FURORE

To continue its Physician-First Service commitment to all its policyholders, ISMIE has analyzed the changing medical marketplace and, based on that research, is introducing new products and services, said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. "These new offerings will give policyholders greater flexibility and more options," he said. "One such enhancement is the opportunity for physician groups to work with insurance brokers or agents if they wish."

As more physicians form larger groups and become

involved with managed care, nonphysicians like group practice administrators are sometimes making insurance buying decisions, Dr. Jensen explained. "Working with brokers is one way we can broaden the distribution of our products into those markets." But Dr. Jensen stressed that ISMIE will continue to work directly with any physician who wants to do so. "No policyholder will be forced to use a broker. It's freedom of choice. If policyholders or prospective policyholders want to use a broker, we'll work with that broker. But if a physician, group or clinic wants to buy

from us directly and maintain contact with ISMIE, they can."

Working with brokers won't directly affect the cost of ISMIE coverage, said an ISMIE analyst. There may be an educational benefit, though. "Given the complexities of managed care structures and practice arrangements, knowledgeable brokers may help insurers like ISMIE better understand insurance expenses, which helps us construct the coverage properly," the analyst explained. "That may make a difference in the premiums. At the same time, ISMIE's underwriting staff is fully prepared to help physi-



Dr. Jensen

cians and their business administrators establish appropriate coverage in the most effective, economical way."

ISMIE plans to work with carefully selected, highly qualified professional brokers who will be required to help ISMIE retain its current business, help provide bids for any new groups or opportunities they become aware of and inform ISMIE about competitors' offerings, the analyst explained. That approach is necessary because of the competitive nature of the insurance business today, he said.

Group administrators, consultants and physicians are also contacting brokers for several reasons. "They may need to find coverage or insurance products ISMIE doesn't offer, like life and health, workers' comp or general liability," the analyst explained. "Because no one insurance company is necessarily capable of satisfying the total needs of any given group, whether it is single-specialty or multispecialty, these brokers are the resources the group's business administrators and physicians typically turn to."

Even if those groups aren't interested in medical malpractice coverage initially, the agent will likely want to write that business, too, said Bill Storie, a broker with Aon Risk Services.

Most insurers, in fact, do business only through agents, the analyst noted. "Using brokers gives you access to markets you can't otherwise get to. And brokers know what those mar-

kets are up to. Perhaps they can help get the product that best fits the needs of their clients."

"Sometimes doctors don't know exactly what to ask for," Storie said. Insurers themselves may not be perceived as the best advisors, so brokers can help physicians and groups determine the kind of coverage they need, he explained.

Storie recently worked on a project that involved the merging of three practices. One of the issues was handling tail coverage. The insurer advised buying out the tail coverage and starting a new claims made policy. "But that's very expensive," Storie said. "I said there could be a single policy naming the predecessor corporations and maintaining the old retroactive dates. The doctor hadn't asked the right questions. A broker can help ask the questions that will get the right answers."

Although competition for business is stiff, many insurers in the medical malpractice market are national companies that write many types of business, Dr. Jensen noted. But ISMIE has always directly written only professional liability insurance and has a 20-year stable track record in Illinois, he said.

"We're owned by physicians, and our staff comes as close as nonphysicians can get in understanding what makes physicians tick," Dr. Jensen explained. "We don't want anyone to be sued, but if you are, we know how to take care of your professional and emotional needs. We understand your persona as a physician." ISMIE, for example, offers doctors the chance to discuss any suit in which they're involved with other physician policyholders through the Physician Review Committee. "You're not going to get that with a commercial carrier," he said.

In upcoming issues, Illinois Medicine will continue coverage of ISMIE's new products and services that aim to provide more options for policyholders.

MALPRACTICE ROUNDUP

Jury finds for physician in negligence, informed consent case

A California jury found in favor of a defendant physician in a case in which a patient claimed the doctor failed to inform him adequately about a medical procedure and pressured him into signing a consent form, according to the September 1995 issue of Medical Malpractice Law & Strategy.

In *Sipe vs. Stein*, the patient had experienced supraventricular tachycardia since 1984 and had received numerous unsuccessful treatments. In 1991, the patient consulted with the physician about a new procedure called radiofrequency ablation, which was performed a year later. Although the patient signed two long consent forms before the procedure was completed, the lawsuit alleged that he was rushed into signing the forms and that the physician failed to address his concerns about possible risks and complications, the article said.

During the procedure, the patient continued experiencing tachycardia, and the physician stopped the procedure and talked with the patient and his wife about how to proceed. When the procedure resumed, the patient developed a complete heart block, forcing the insertion of a pacemaker. Because of conscious sedation, the patient did not recall giving his consent to continue the procedure, and his wife claimed she was intimidated into signing the consent form, the article noted.

The jury found that negligence had not occurred and that informed consent had been obtained at every stage of the procedure. ■

Physician did not breach standard of care

A Louisiana appeals court ruled in August 1995 that a physician who did not inform a patient about the results of a bone scan did not breach the standard of care, according to a case summary in the September 1995 issue of Cancer Litigation Update.

The plaintiff in *Gardner vs. McDonald* claimed the doctor breached the standard of care when he "ignored recommendations to take a film study after abnormal bone scans, failed to perform a differential diagnosis after observing abnormalities and failed to inform her of the results of the scan and the recommendations of the radiologists," the story explained.

But in affirming a verdict for the physician, the appellate court said there was no evidence that the doctor had breached the standard of care. "He had reviewed the report of the scans and decided that without further symptoms indicating cancer, it was not necessary to tell [the] plaintiff her cancer had metastasized. Because of the emotional and psychological toll the revelation of incurable cancer takes on a patient and her family, the doctor had reasonably decided she did not need to know until the results were conclusive," the case summary said. ■

Ending your practice? Here's how to minimize risks

Transferring patient care and maintaining insurance coverage are vital. BY KATHLEEN FURORE

Deciding to sell or close a practice is seldom easy. But once the decision has been made, physicians must do more than hang a "For Sale" or "Closed" sign on the office door. They must notify patients, transfer patient records and make sure they have medical malpractice insurance in case former patients sue them someday, defense attorneys said.

"I recommend that doctors send a letter to all their patients telling them the practice has been sold or will close," said Jeff Glass, an attorney in the Belleville office of Hinshaw & Culbertson. "Say Dr. Jones sells his practice to Dr. Smith and transfers records, it's not [legally] safe if the patients aren't involved. The key is to make sure the patient is involved in requesting the transfer of records to another doctor."

Physicians selling their practices should let patients know the date the practice will close, the location and date their records will be available and the purchaser of the practice, according to risk management specialists. Glass advised physicians to inform each patient in writing that his or her records will be transferred to the purchasing physician unless the patient requests otherwise within 30 days.



Physicians who are closing their practices should also notify patients of their plans and try to make sure those patients select a new physician. "That's where a letter [from the physician] is very important," he said.

Keeping patients updated is necessary to ensure continuity of care, Glass said. "You're giving patients a hand in choosing [a physician] so there is no gap in the care being given."

The emphasis on continuity of care was reinforced by Judee Gallagher, an attorney in private practice in Chicago and a member of ISMS' Lawyer Referral Network. "You have to avoid patient abandonment issues," she said. "If you just disappear, what if someone has a follow-up visit and can't find you?"

It is also crucial that physicians document and keep copies of all communication involved in notifying patients and transferring records. "The original doctor is the custodian of patient records," Glass said. If a lawsuit arose and records had been lost, for example, facts related to the transfer could be questioned.

The original physician doesn't need to keep copies of the actual records, though, according to attorney Joe Camera of Cassidy, Schade & Gloor in Chicago. But he said the original physi-



cian must make sure the records are transported and that the purchaser acknowledges the transfer in writing, because "someone could always say they never got them." The acknowledgment should include a list of all records being transferred, Camera added. Physicians should get it in writing – usually through a contract – that the purchasing physician will preserve or maintain the transferred records.

Physicians also should ask patients who pick up their records to sign a receipt, and they should keep those receipts, Glass said.

Physicians who close their practices and do not transfer records to another provider are responsible for preserving those records, the attorneys said. With an eye on the statute of limitations, Glass advised doctors closing their practices to keep adults' records for at least four years from the date the practice closes and minors' records for at least eight years.

Camera recommended that physicians save children's records for more than eight years because the statute of limitations can be longer than that in some pediatric cases. In March 1995, an Illinois appellate court ruled that the statute of limitations will never expire for per-



manently disabled minors, according to the June 1995 issue of Medical Malpractice Law & Strategy. Although the Illinois Code of Civil Procedure states that claims on behalf of children under 18 must be brought no more than eight years after an alleged malpractice, the court ruled that the period of limitations does not begin until the disability is removed. The case that triggered the ruling involved a severely mentally disabled 16-year-old. The court noted that the limitations period would never begin in this case because the plaintiff had been disabled since birth, the article said.

Maintaining professional liability insurance that will cover past actions is also of utmost importance for physicians leaving their practices for whatever reason. "Make sure you've bought a tail [policy] to protect you," Camera said.

To get tail coverage without a premium charge, ISMIE-insured physicians must have been insured with ISMIE for five continuous years, must be at least 55 years old and must be retiring from the practice of medicine, according to an ISMIE analyst. Even if retired physicians assume administrative positions, as long as they do not provide medical care, they can still qualify as being retired, he added. "It's part of the product ISMIE offers."

If an ISMIE policyholder sells a practice and joins the purchaser in practice, the seller can still continue with ISMIE as long as the purchaser is also covered through ISMIE. "If not, physicians should make sure their new insurance includes prior acts coverage," the analyst said. ■

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CONTRACTING

Physician autonomy gives patients the protection they need

The ruling in the Berlin case reinforces the Medical Practice Act and the need for doctors to make medical decisions.

By Kathleen Furore

You're a general surgeon employed by the only hospital in town. You think one of your patients needs surgery performed in the hospital followed by two days of on-site care. But your employer will sanction only outpatient surgery.

Such a situation can happen because some hospitals are employing physicians in spite of the Medical Practice Act of 1987, which used legal language that has been in existence since 1923. The law states that only individuals licensed to practice medicine – not hospitals – may engage in medical practice.

That ban on the corporate practice of medicine became an issue in the recent case involving Richard Berlin, MD, a general surgeon whose contract with Sarah Bush Lincoln Health Center was ruled unenforceable by the Fifth Judicial Circuit Court in Charleston on June 15, 1995. The court said Sarah

Bush Lincoln could not employ physicians because it is not licensed as a medical or professional service corporation. The hospital's contract with Dr. Berlin provided that Sarah Bush Lincoln would set all fees and would have the exclusive right to bill for Dr. Berlin's services, an arrangement prohibited by the Medical Practice Act.

The health center filed an appeal Oct. 19, 1995. In support of Dr. Berlin, ISMS, five county medical societies and the AMA filed a joint amicus curiae brief on Nov. 22. ISMS submitted the brief because the issues of physician independence and its effect on the quality of patient care are so important to doctors and their patients, said ISMS General Counsel Saul Morse.

The Berlin decision did not set precedent, because the ruling was made by a trial court. But even if the decision is upheld, doctors and hospitals will still be able to enter contractual relationships "that guarantee



David Ridley

C O N T R A C T I N G

that physicians can treat their patients but keep the medical decision-making where it ought to be – with the physicians,” Morse said. “Life is different when you think you can be fired because of decisions you make, instead of having the autonomy an independent contractor relationship gives you. The key issue here is the ability of physicians to make medical determinations without fear of being fired or unemployed because nonmedical people are more worried about cost than quality of care.”

The Berlin case could help clarify the types of physician-hospital arrangements that are legally acceptable. Dr. Berlin’s attorney, Cam Dobbins, said he expects the Illinois legislature to address the issue eventually. “With the increasing move toward managed care, entities are buying up practices and employing physicians,” he said. “If managed care organizations aren’t licensed, they can’t employ doctors without legislative change.”

“I don’t see ISMS as saying physicians and hospitals shouldn’t form alliances,” said ISMS 12th District trustee and Rockford physician William Kobler, MD, who recently sold his practice to OSF Healthcare System. “I think what’s important is that we should strive for physicians to have autonomy in the practice of medicine.”

There are distinctive differences between employer-employee relationships as opposed to independent contractor relationships between physicians and hospitals. Not only are employees paid by the hospital, but they also receive benefits from the facility. “If they are employees in the literal, legal sense of the word, they receive all benefits from and have a fiduciary obligation to their employer,” Morse said. “It’s a question of who can fire them. Independent contractors, on the other hand, might receive a check from the hospital but nothing more. It’s just like a hospital buying food from Jewel. The hospital buys a product and sends a check. The hospital certainly can terminate the contract, but it’s a bit more difficult. The independent contractor has certain rights under the contract.”

To avoid violating Illinois law regarding the corporate practice of medicine, physicians should make sure any contract they sign with a hospital guarantees that physicians make all medical decisions and that those decisions undergo peer review, Morse said. “We’re not saying no one should review a physician. We’re just saying it shouldn’t be the chief financial officer, for instance.”

Physicians may also sell their practices to hospitals as long as after the sale, those doctors become independent contractors, not employees of the purchasing hospitals, Morse said. “Can they sell their assets? Yes. Can they sell their assets and then become employees of that hospital? No. It has always been ISMS’ policy that physicians should owe their loyalty and fiduciary obligation to patients and not non-physician employers.”

Concerns about maintaining physician direction and autonomy and preserving the quality of patient care caused five county medical societies – in Chicago and Champaign, Lake, Livingston and Winnebago counties – and the AMA to file the amicus brief with ISMS. “We thought that if Dr. Berlin prevailed in the suit, it might set a precedent beneficial to the rank and file of our membership,” said James Monahan, MD,

president of the Lake County Medical Society.

“We need to enable doctors to be full advocates for patients and to recommend the care they feel is in the best interest of their patients,” said attorney Ed Hirshfeld, AMA vice president for health care law. “As [hospital] employees, physicians have a fiduciary relationship with the hospital and its stockholders. The concern is the inappropriate influence [hospitals could exert] over physicians’ clinical judgment.”

In some states – California, for example – the corporate practice of medicine has been addressed by the development of foundations for medical care, Hirshfeld explained. Many hospitals and health systems have cre-

(Continued on page 10)

An overview of the Berlin case

The Berlin case has been covered in Illinois Medicine for several months, but for those who aren’t familiar with it, the following provides some background. In December 1992, general surgeon Richard Berlin, MD, signed a five-year employment agreement with Sarah Bush Lincoln Health Center. The contract prohibited him from affiliating with “any person, firm or corporation engaged in competition with Hospital in providing health care services within a 50-mile radius” during the term of the contract and two years thereafter.

Dr. Berlin resigned Feb. 7, 1994, and immediately began working for the Carle Clinic Association’s Mattoon-Charleston branch, one mile from the hospital. On Feb. 8, Sarah Bush Lincoln filed suit to enjoin him from practicing at Carle.

Although Dr. Berlin ultimately left Carle to go into private practice, he sued Sarah Bush Lincoln, seeking a declaratory judgment and claiming that his contract’s restrictive covenant was unenforceable. The primary contention was that a hospital has no legal right to stop a doctor from working for a competitor within its service area. Dr. Berlin also claimed his contract violated the Medical Practice Act, which prohibits the corporate practice of medicine and the kind of fee-splitting arrangement spelled out in his contract – namely, that the hospital would set all fees and have the exclusive right to bill for Dr. Berlin’s services.

On June 15, 1995, the Circuit Court of Coles County found Dr. Berlin’s employment agreement with Sarah Bush Lincoln void and against public policy. The court stated that only individuals licensed to practice medicine – not hospitals – may engage in medical practice.

The Sarah Bush Lincoln Health Center filed a notice of appeal in the 4th District Court in Springfield. A decision is expected this spring. ■

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Physician autonomy

(Continued from page 9)

ated those foundations "by purchasing all of a large physician group's practice assets, applying for and obtaining tax-exempt status from the IRS and then contracting with the former physician-owners to provide medical care to what are now the 'foundation's patients,'" wrote the California Medical Association's chief legal counsel, Catherine Hanson, in California Physician magazine.

However, there is no law that expressly exempts hospital-controlled foundations from the corporate practice ban, Hanson noted. Consequently, "physicians contemplating foundation affiliation should satisfy themselves that the venture protects medical practice from lay interference and commercial exploitation and obtain a legal opinion from foundation counsel," Hanson wrote. "Generally speaking, physicians will want to ensure that they will retain exclusive control over the clinical aspects of medical care and maintain a right to modify and approve foundation policies and practices that might influence the exercise of their professional judgment."

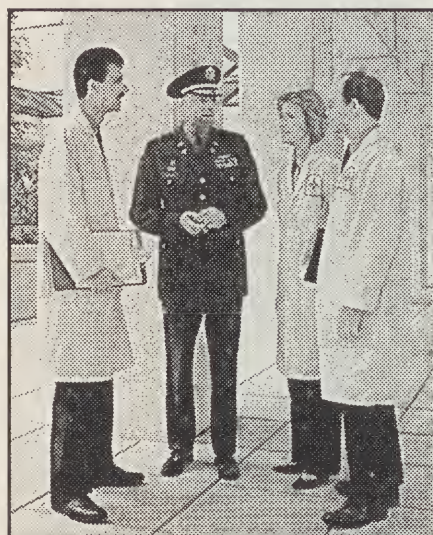
The situation is similar in Texas, according to Texas Medical Association General Counsel Rocky Wilcox. "We still have a ban on lay entities hiring physicians, charging fees and paying a salary [to physicians]." Texas doctors, however, can sell their practice's assets to "some affiliate of the hospital," he said. "The critical thing is who is really in control."

AN ARRANGEMENT POPULAR in the nonprofit hospital arena is for physicians to sell their practice assets to a nonprofit health corporation that has an all-physician board of trustees, he said. "The hospital finds a friendly doctor or group of doctors to form the corporation, which then adopts bylaws that allow the hospital to be a member," Wilcox said. Any contracts signed are then between the nonprofit health corporation and the hospital. However, the state's Board of Medical Examiners has issued rules to ensure that all medical decision-making rests with physicians, he noted.

In the for-profit marketplace, some Texas hospitals are signing agreements with physicians or physician groups to develop practices, Wilcox said. "They set up a professional association. The shareholder is the doctor. Funding and hiring are handled by the hospital." In essence, the hospital is using the physician's license to establish a new practice that has a special relationship with the hospital, he said. But he cautioned that this kind of arrangement can come with strings attached. For example, the hospital may contract with doctors, but if they decide to leave, the facility may ask them to sign over their shares to physicians chosen by the hospital, he explained. "There can be so many controls that it becomes hard to tell if the physicians [are or] are not employees. It should be set up so the doctors are nonemployees of the hospital. They should still be in charge."

What does this mean for Illinois physicians? "Until the appellate court rules on the Berlin case, physicians really need not take any action," Morse said. "If they're interested in concepts like the foundations [for medical care], they need competent, experienced legal help in setting one up." ■

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Underwriting conference tackles federal tort reform

PROGRAM: Speakers urge legislation to stem out-of-control litigation. BY KATHLEEN FURORE

[CHICAGO] Legal action resulting from medically unsupported but emotionally charged allegations about the drug Bendectin and silicone breast implants are examples of why the nation needs tort reform, said AMA Executive Vice President James Todd, MD, at the Professional Liability Underwriting Society's international conference last fall at the Sheraton Hotel in Chicago. "The current professional liability situation is beginning to determine the standards of medicine, based upon emotional courtroom activity," he said.

"Bendectin – a very useful drug for women during their pregnancies – was driven off the market because of the civil justice system, with no scientific evidence whatsoever that it ever harmed anyone," Dr. Todd explained during a roundtable discussion moderated by newsman Marvin Kalb. "The same is happening today with silicone breast implants. Article after article cite no relationship between silicone breast implants and collagen diseases, and yet we have a lawyer in Texas who is making \$4 billion a year because he set up a 1-800 number to attract women who had breast implants. If [the situation] is not corrected, we will not be able to sustain the civil justice system because it will be clogged with cases beyond anybody's ability to even imagine."

The medical profession supports a cap on noneconomic damages awarded for pain and suffering, which "are not measurable by any standards I know," Dr. Todd said. However, he noted that "economic damages will be fully compensated."

Also speaking in favor of tort reform were panelists Warren Rudman, former New Hampshire senator; Dennis Chookaszian, chairman and CEO of CNA Insurance Companies; Walter Tomenson Jr., chairman and CEO of Marsh & McLennan FINPRO; and attorney Thomas Wilson, senior partner of Wilson, Elser, Moskowitz, Edelman & Dicker. All concurred that the current system has not only overburdened the courts, but also created a lottery system in which awards have skyrocketed.

"Eventually, this is going to destroy the American insurance industry because they won't have the capitalization to cover some of these cases," Rudman said.

The pro-reform panelists said tort reform is a federal issue because, in Rudman's words, "we need some common ground across jurisdictions." Currently, a plaintiff could win \$2.7 million in one jurisdiction but only \$50,000 in another for the same case, Chookaszian noted.

Harvey Weitz, a New York attorney and past president of the New York Trial Lawyers Association, was the lone panelist opposing reform. "I would like to try to bring some reality back to the discussion," he said. "It seems to me people here are so intent upon what is called tort reform that they're going to destroy the American judicial system. [The courts] are not clogged with tort cases – that just is not true. They are clogged with criminal cases."

Weitz also questioned Dr. Todd's assessment of the breast implant situation. "I deal with hundreds of these peo-

ple, and it just stretches the imagination to believe it's all coincidence that they have autoimmune diseases and silicone implants," he said.

In a later session, attorneys discussed the Republican Party's Contract with America and its impact on tort reform. AMA counsel Martin Hatlie presented the physician side of the national debate.

"This [tort reform] is a terrifically

important issue for doctors," Hatlie said. "There are two things generally driving the issue: cost and access to health care."

Physicians and hospitals spend some \$12 billion per year on malpractice premiums alone, he said. "There are women who can't find an obstetrician to deliver a baby" – a predicament Hatlie said is linked to the high premiums paid by Ob/Gyns.

The current liability climate also drives doctors to practice defensive medicine, which escalates costs for them and their patients and breaks down the physician-patient relationship, Hatlie said. "About 75 percent of [malpractice] claims [filed] are nonmeritorious. [So] getting sued is almost a total crapshoot. Doctors have to treat every patient as a potential litigant. The system is working well for lawyers, but it's not working well for patients and doctors.

"It might take another election cycle [before medical malpractice reform is enacted], but we guarantee we will keep coming back [until it is]," Hatlie said. ■

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(Continued from page 1)

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"Because I feel strongly that change is essential to the delivery system for health



Dr. Downey

care – both public and private – I went back to school at the Krannert School of Management at Purdue University in 1993," Dr. Downey continued. "I completed my master's in management in 1995."

The primary component in running a successful business is providing for the health and welfare of employees, Dr. Downey added. "Care must balance quality, accessibility and cost – not an easy equation but one that some physicians and some employers have been tackling together for decades."

"We, as physicians and employers, must come together because we recognize and want to meet our mutual obligation of caring for people – not because any agents or middlemen hold a gun to our heads for their separate purposes," he continued. "Success can best be built on direct relationships that maximize value-

added by focusing incentives and accountability right where they ought to be – on the practicing doctor who makes the decisions about diagnosis and treatment and who therefore drives the majority of costs. Direct partnerships can also focus the greatest possible portion of employee's health care dollar on the care of patients rather than on the overhead and profit of the middlemen.

"The incentive to give good care is not new," he said. "The incentive to do it at a good cost is new. Effective physician-employer partnerships are built on the foundation of physicians meeting a twofold obligation as their part of the bargain: to improve the quality of care and to improve the efficiency of the process of care. Physicians are reinventing their partnership capabilities through increasingly sophisticated approaches, both in the practice and business of managed care."

"Physicians have been given a unique window of opportunity by the public to redefine health care for the 21st century," said Pamela Paul-Shaheen, director of operations for the Comprehensive Community Health Models of Michigan. "It is clear that the public is not interested in a governmental solution, but it is also clear that they are very interested in being afforded access to high-quality services and that they are looking to the private sector to make it possible."

Reshaping the health care system will require visionary leadership by purchasers and providers, Paul-Shaheen said. "Purchasers must move from an

orientation of discount purchasing to one of outcomes-based 'value purchasing.'" More work must be done in communities to develop opportunities for smaller employers and individuals to buy insurance at an affordable cost, and employers must fund outcomes-based research and work with providers to support the continuous improvement of quality, she explained. She noted that the Kellogg Corp. in Battle Creek, Mich., has formed a partnership with communities to make health care more accessible and affordable.

Providers, on the other hand, must "get smart" about effective integration of health systems and must recognize that they must form and work effectively

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in larger organizations and in teams, Paul-Shaheen said. "The days of medical care as a cottage industry are no more, and providers, particularly physicians, must recognize they now operate in a virtual provider community – one composed of human services professionals, mid-levels, primary care providers and specialists, all working together to meet the needs of their patients."

A discussion of providing care through partnerships inevitably leads to the subject of contracting. "For primary care physicians, the ability to develop and successfully manage physician-driven organizations, where they do their own contracting, is paramount," said James Downey, MD, a pediatrician and president of the Evanston-Glenbrook Physicians Association, an independent practice association. Dr. Downey was part of a group of primary care physicians at Evanston Hospital who formed the association two years ago. Today, 85 primary care physicians, including 18 Ob/Gyns, are members of the association, he said.

"The most important issue for us as a group was the ability to do [contracting] on our own," said Dr. Downey. "We have one PPO contract with Blue Cross and Blue Shield of Illinois and one point-of-service contract with Rush-Presbyterian-St. Luke's Medical Center. About a month ago we sat down with Aetna. We are also now in the middle of negotiating other contracts. [And] we're looking to expand our association with other physician groups at hospitals. We are planning to expand our geographical coverage."

Currently, 2 percent of the association's practice is composed of fee-for-service patients, and the group capitates some of its specialized care, Dr. Downey said. "Full capitation is the best way, however, because there's no bad debt."

To help ISMS members interested in directing managed care and to provide administrative support for all ISMS members, the Society has proposed the development of the Physician Services Organization. It would assist physicians in such areas as contract and utilization review, practice management and information systems.

IDPH appoints

(Continued from page 1)

statewide approach to preventing all types of violence, according to an IDPH news release.

"Dr. Olson was chosen to be a member of the authority based on her interest, knowledge and leadership on the topic of violence," said Dr. Lumpkin, who co-chairs the authority with Attorney General Jim Ryan.

Dr. Olson created an ad hoc presidential committee on violence when she



Dr. Olson

served as the 1993-94 president of the Chicago Medical Society. During ISMS' 1994 Annual Meeting, she introduced a resolution calling for a ban on firearms, which was referred to the Board of Trustees

for action and ultimately passed. She also serves on the attorney general's Violent Crimes Advisory Commission and was a member of the Illinois Family Violence Coordinating Council.

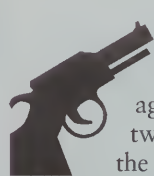
"I am pleased and honored to be one of the members [of the authority] and to be able to do what I can to help in this important public health problem," Dr. Olson said.

The authority – which had not yet met as Illinois Medicine went to press – will plan, coordinate, fund and evaluate public health and public safety approaches to violence prevention, according to IDPH. It will distribute grants to community and statewide organizations that address prevention, an IDPH news release said.

The authority is providing the seed money for grants, but community involvement is so important. Rewards will be reaped best within the communities.

The authority is interested in such initiatives as after-school, community-based activities for teens, early childhood programs for children at risk and programs to help prevent substance abuse and family violence, said Secretary of State George Ryan in December 1995, when he unveiled a specialty violence prevention license plate that has been available to Illinois drivers since Jan 1. The plate – decorated with a white dove carrying an olive branch and the letters PV for "prevent violence" – costs \$88, with \$25 of that cost earmarked for the authority. Funds for the group also will come from private, state or federal sources for violence prevention, the release said.

Violence is a public health issue



Andre, or "Slugger," as he was known by his fellow gang members in Kankakee, was shot three years ago and lay comatose in a hospital bed for two months. Today, Andre is paralyzed from the waist down and confined to a wheelchair.

"Before I got shot, I didn't take anything seriously. I just shot at people," he told a group of medical students last fall at a symposium on violence prevention sponsored by Physicians for Social Responsibility, a national advocacy group with 15,000 members.

Andre was among four panelists who described the horrors of guns and gangs in their communities. Another panel of physicians from Cook County Hospital discussed the medical consequences of gun violence, such as trends that trauma surgeons are witnessing.

"Violence starts small and it builds until it becomes a problem, said Lee Francis, MD, president of PSR's Chicago Chapter. "Today, violence has grown from a small problem to a problem of epidemic proportions."

Dr. Francis noted that treating violent injuries is not limited to trauma surgeons but involves general surgeons and primary care doctors as well. "There is no way to avoid these issues of violence. Violence is not so much a social problem but a medical problem. And it is time that we start thinking of violence as a medical problem."

"In a medical sense, if you're going to be a primary care doctor taking care of a young population in an urban area, your patients are going to be at risk of dying not from cancer or pneumonia but of homicide from a gunshot," said John May, MD, the symposium moderator and a senior staff physician at CCH's Cermak Health Services in Chicago.

Gunshot wounds were the leading cause of death at trauma centers in the Chicago metropolitan area for the

last two years, said Roxanne Roberts, MD, associate director of Cook County Hospital's trauma unit. "They caused hospital admissions to increase 36 percent from 1989 to 1993. Now, there are more gunshot wound deaths than motor vehicle deaths in trauma centers." Dr. Roberts pointed to Lutheran General Hospital in Park Ridge as one facility that is not a big urban trauma center but still has been affected by the rise in gunshot wounds.

At Children's Memorial Medical Center in Chicago, pediatric firearm deaths increased 81 percent from 1980 to 1994, and gun trauma was the No. 1 cause of death for 15- to 19-year-olds in the city last year, according to a report issued by the Children's Violent Injury Prevention Center.

To reduce some of the lethal aspects of violence, "we could approach it as a public health issue," said Robert Smith, MD, medical director of Chicago's Injury Control program and chairman of the Prehospital Care and Prevention Trauma Unit at CCH. "This idea is relatively new. We feel it's appropriate, and more and more health professionals are advocating that this is a reasonable approach to looking at violence."

A similar approach was approved last year by the ISMS House of Delegates when it adopted a resolution calling on the Society to support legislation mandating the initial steps of a statewide public health plan. Gov. Jim Edgar signed that legislation, H.B. 1977, last August. It requires hospitals and other facilities to report to the Illinois Department of Public Health any injury allegedly caused by a violent act. Another measure supported by ISMS and signed by Edgar, the Illinois Violence Prevention Act of 1995, requires the state's Violence Prevention Authority to develop a plan that incorporates public health and safety approaches to violence prevention.

— Mary Nolan

"This is an important effort to encourage other groups to initiate programs so they can apply for funding," Dr. Olson said. "Perhaps we'll see a snowball effect. The authority is providing the seed money for grants, but community involvement is so important. Rewards will be reaped best within the communities."

Also appointed to the authority by Dr. Lumpkin were Leonard Hawthorne, principal of Lewis and Clark School in

Godfrey; Raymond McCaskey, president and chief executive officer of Blue Cross and Blue Shield of Illinois; and Barbara Shaw, executive director of the Illinois Council for the Prevention of Violence. Jim Ryan appointed George Graves, chief of the Downers Grove Police Department; Polly Poskin, executive director of the Illinois Coalition Against Sexual Abuse; Charles Reynard, McLean County state's attorney; and Vickie Smith, executive director of the Illinois

Coalition Against Domestic Violence.

Other authority members will include the director or designee from the Illinois departments of Aging, Alcohol and Substance Abuse, Children and Family Services, Mental Health and Developmental Disabilities, and Public Aid; the Illinois State Police; the Illinois State Board of Education; and the Illinois Criminal Justice Information Authority, the release said.

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ISMS' patient rights bill prohibits gag rules

ADVOCACY: Society announces introduction of
MCPRA; AMA calls on plans to cancel gag clauses.

BY KATHLEEN FURORE

[SPRINGFIELD] At a Feb. 6 news conference in Springfield, ISMS announced the introduction of the Managed Care Patient Rights Act into the Illinois General Assembly. The comprehensive bill would provide patients with specific rights and protect them from such practices as the use of gag clauses, which prohibit physicians from telling patients about treatment options their managed care plans don't cover.

"The [proposed] legislation includes a provision that will make it illegal for managed care plans to have a gag rule in Illinois," ISMS President Raymond Hoffmann, MD, told Illinois Medicine as the publication went to press. The March 1 issue of Illinois Medicine will include coverage of the news conference.

"ISMS believes that physicians and other health care providers must be allowed to provide full and complete information to their patients," Dr. Hoffmann said. "No managed care plan should be allowed to intervene in the physician-patient relationship. Such intervention cannot improve care. It can only adversely impact the

quality of care provided to patients."

The bill states that "no managed care plan may prohibit or discourage health care providers from discussing any alternative health care services or providers with enrollees."

The AMA on Jan. 23 called on all managed care plans to immediately cancel gag clauses in their contracts or policies with physicians because of "unethical interference in the physician-patient relationship." In some cases gag clauses may even prevent doctors from referring very sick patients outside their plans, according to an AMA news release.

"The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan," said the AMA's Council on Ethical and Judicial Affairs. "Patients cannot be subject to making decisions with inadequate information. That would be an absolute violation of the informed consent requirements."

"AMA physicians cannot abide by gag clauses," said

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ISMS holds
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in Peoria



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Speakers at an ISMS program Jan. 21 at the Chicago Medical Society's Midwest Clinical Conference included (left to right) Dr. Downey, Dr. Halaas, Ray and Dr. Traugott.

CMS conference features ISMS seminar on physician- driven managed care

WORKSHOP: Speakers at the Midwest Clinical Conference say physicians must take control to make managed care work for doctors and patients.

BY KATHLEEN FURORE

[CHICAGO] "Physicians Seizing the Reins of Change" was the theme of an ISMS-sponsored seminar presented Jan. 21 during the Chicago Medical Society's 1996 Midwest Clinical Conference at the Sheraton Chicago Hotel & Towers. Moderated by ISMS President Raymond Hoffmann, MD, the workshop was designed to help physicians identify managed care initiatives and trends and learn how to assume control in managed care.

Other speakers were ISMS Past President Arthur Traugott, MD; managed care consultant John Ray; pediatrician James Downey, MD, president of the Evanston-Glenbrook Physicians Association, an independent practice association; and Gwen Halaas, MD, associate medical director of the Contracted Care Division of HealthPartners in

Minnesota.

In his opening remarks, Dr. Hoffmann noted that "the financial agenda of insurance-driven managed care organizations is radically changing the way the business aspects of medicine are handled. Our challenge as physicians is to make sure these financial objectives do not alter the practice of medicine itself. If we ever stop being the patients' advocates — if physicians become the advocates of an insurance company or insurance plan — we've really lost it all."

One of the initiatives discussed was ISMS' proposed statewide Physician Services Organization. The proposal for the PSO was developed as a result of an independent 1994 study that examined how ISMS could help its members adapt to

(Continued on page 11)

Don't forget the ISMS House of Delegates Annual Meeting

The 1996 ISMS House of Delegates Annual Meeting will convene April 19-21. This year's meeting will again be held at the Oak Brook Hills Hotel, 3500 Midwest Road in Oak Brook.

The deadline for receipt of resolutions is the close of business March 19; a March 19 postmark is not sufficient. Resolutions received at ISMS offices after that date will be reviewed by the Committee on Rules and Order of Business to determine whether the house will consider them. Only delegates and voting members of the house may submit resolutions.

Resolutions should be addressed to Richard Ott, Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

The ISMIE Annual Meeting is scheduled for Wednesday, April 17, and will also be held at the Oak Brook Hills Hotel.

Informational materials and meeting packets will soon be mailed to House of Delegates members. For more information about the ISMS and ISMIE annual meetings, call (312) 782-1654 or (800) 782-ISMS. ■

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Updated guide clears the air on smoke-free Illinois restaurants

[CHICAGO] Some 50 new restaurants have been added to the American Cancer Society's updated guide listing smoke-free restaurants in the Chicago metropolitan area and Downstate.

The guide groups about 200 restaurants according to location and lists type of cuisine and price range. Restaurants range from fine dining and ethnic cuisine to sandwich shops and national chains. The directory also notes restaurants that permit smoking in a bar separate from the dining area.

"We are delighted to see so many restaurants responding to the marketplace by providing smoke-free environments," said Nicholas Vogelzang, MD, president of the Illinois Division of the ACS. "The American Cancer Society commends these restaurateurs on their concern for the health of the clientele

and workers."

Ken Pospiech, owner of the Lucky Platter restaurant in Evanston, said that his decision to have a smoke-free establishment grew out of a personal preference. "When I opened the restaurant five years ago, I decided I just didn't like smoke. It doesn't work in a restaurant."

Nonsmokers tend to be more vehement in their opposition to smoking than smokers are about their right to smoke, he added.

"Three out of four Americans are nonsmokers," Vogelzang noted. "We are finding that many consumers are unwilling to subject themselves and their children to the hazards of secondhand smoke."

Physicians who would like to distribute free copies of the guide in their offices may call (800) ACS-2345. ■

Law on parental notification for teen abortions dies

[SPRINGFIELD] A law requiring physicians to notify parents or guardians of teen-agers seeking abortions is essentially dead, the result of the state Supreme Court's refusal to issue rules that would allow teens to request exemption from the notification requirement. Without those rules, the law cannot be enforced.

The law would have required women 18 and under to wait 48 hours before getting an abortion, during which time their physicians would have had to notify a parent, grandparent or guardian. Although the young women could have asked a judge to waive that requirement, waiver requests that were denied by a judge would have been handled by the court. ■

Market STATS

Chicagoans less satisfied with health insurance coverage

Chicago residents have grown less satisfied with their health insurance coverage in the past year, according to a survey by Sachs Group, an Evanston health care market research firm. The percentage of survey participants who said they were satisfied or very satisfied with their insurance dropped in all six categories surveyed – access to urgent care, quick claims handling, range of services, quality of doctors, quality of hospitals and location of hospitals.

Crain's Chicago Business
Jan. 15, 1996

Information network to include clinical transactions

A 34-member coalition of providers, payers, employers and other health care organizations formed a huge community health information network in California in August 1995. The coalition, Healthcare Data Information Corp., said the network will initially focus on business transactions and will add clinical transactions to the information base.

Physician Executive
November 1995

Texas doctors join the insurance game

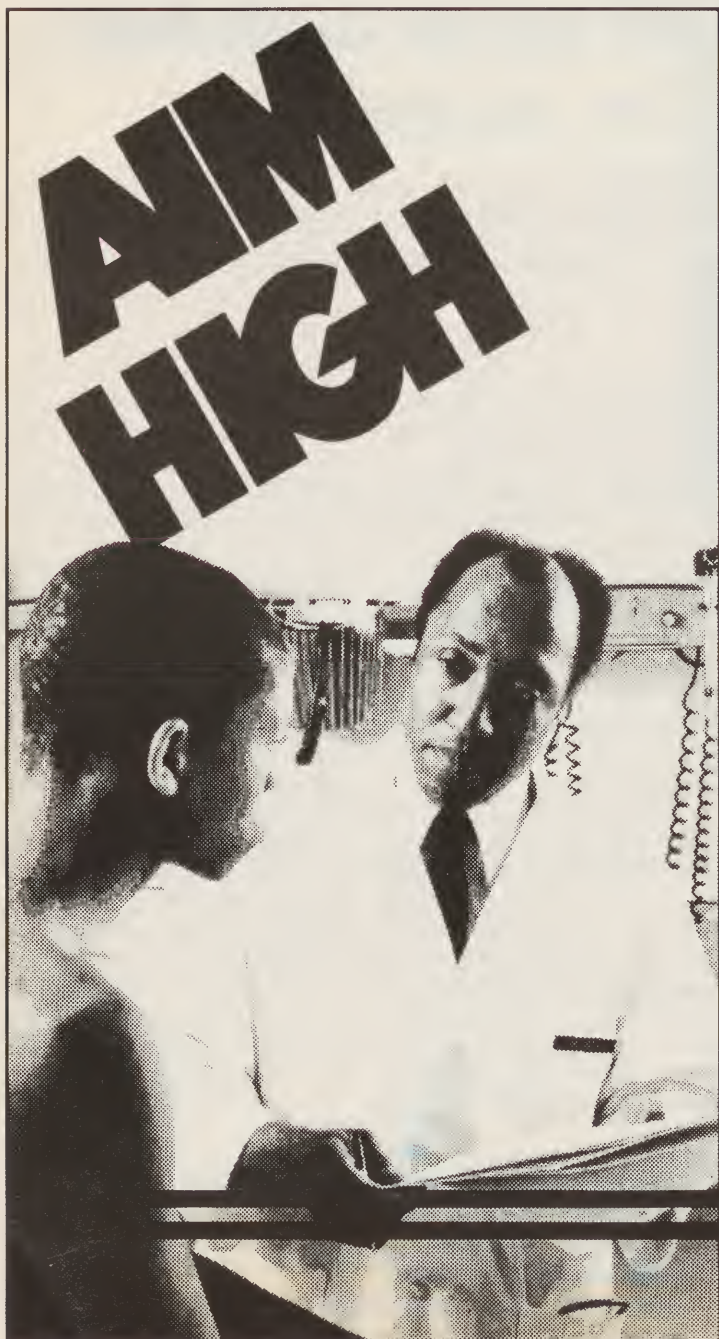
Nearly 200 Houston physicians have put up the seed money to create their own insurance company. Organized under the auspices of the Gulf Coast Independent Practice Association – which was created by the Harris County Medical Society a decade ago – the venture is intended to give patients and employers insurance options at competitive prices and to reduce physicians' administrative headaches.

Texas Medicine
January 1996

Good health means money

Employers are increasingly using money to motivate their employees into healthier behavior, according to a 1995 survey by Hewitt Associates. From 1993 to 1994, the 1,035 employers surveyed showed a marked increase in the use of financial incentives and disincentives. An example of an incentive would be reimbursement for completion of smoking-cessation classes, and a disincentive would be higher medical or life insurance premium for smokers.

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ISMS holds PSO workshop in Peoria

MANAGED CARE: Series begins Downstate. BY MARY NOLAN

[PEORIA] "We're in control. We just don't know it," said John Jurica, MD, at a recent ISMS workshop on the Society's proposed Physician Services Organization. The Jan. 17 seminar in Peoria was one of seven such programs held in Chicago, Springfield, Champaign, Rockford, Carbondale and Collinsville.

Physicians must overcome their sense of powerlessness and the fear that they can't compete with HMOs and other managed care entities, explained Dr. Jurica, a family physician from Kankakee. "You have to understand that a hospital is just an empty building where physicians are admitting patients and taking care of them. Nothing happens in a hospital without physicians."

Physicians need certain characteristics and elements to form a successful physician-driven managed care organization, he continued. They include leadership, commitment, capital, management and the ability to ask for help on legal or business matters.

Some physicians fear managed care because it has brought abrupt changes and disrupted their practices, according to Richard Snodgrass, MD, a cardiologist in Moline and an ISMS Fourth District trustee.

Part of the solution is recognizing the opportunities afforded by physician-driven groups, Dr. Jurica said. "I don't mean that we have to monopolize. But [when we form these groups], we have to be more efficient and do utilization reviews and other managed care activities."

Dr. Jurica warned physicians about the dangers of letting nonphysicians make health care business decisions. "There are other forces that are going to be encouraging physicians to consolidate. We will have to become efficient anyway, whether it's under an HMO, PPO or whatever. Things are consolidating. You don't see the five-and-dime store anymore; you see the Wal-Mart. You don't see the individual shoemaker; you see the shoe factory."

Physician leadership in managed care is no longer an oxymoron, but a necessity, Dr. Snodgrass said. He acknowledged, however, that "while some physician group practices are willing and well-prepared to contract with payers to deliver care to enrollees for a set payment per month, most are not."

Physicians who are unprepared for managed care contracting or who want to assume a leadership role can find help from a variety of resources.

Dr. Jurica noted that when he and his colleagues first looked at forming a physi-

cian-driven organization two years ago, "[our area] did not have a single capitated plan in the county. But we saw the handwriting on the wall," he said, referring to a coalition of local businesses that had solicited an HMO's help to address health care costs. "I did background checks on IPAs and POs, and contacted ISMS and the AMA and their consultant and referral services. Eventually, we decided to

become a physician organization."

Premier, the PO formed by Dr. Jurica's group, includes 37 physicians – 13 primary care doctors and 24 specialists – and has managed care contracts with Humana and HMO of Illinois.

ISMS' proposed Physician Services Organization will be another important resource for individual physicians, medical groups and large physician groups,



Dr. Jurica

Linda K. Henson

providing consulting, purchasing, practice management and informational services to members, Dr. Snodgrass said. "The proposed PSO would create a toolbox [that] would be available to physicians who choose to engage in managed care contracting and seek assistance in any number of ways," he said.

Edward Fesco, MD, a general surgeon in LaSalle and an ISMS Third District trustee, said the Society's PSO will help physicians analyze their options and set a course for the future. "We're testing the waters to develop a realistic strategy to plan for what the practice of medicine will face in the next decade." ■



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REPORT for Illinois Physicians

PAYMENT OF SERVICES OF TEACHING PHYSICIANS UNDER MEDICARE

The Health Care Financing Administration has clarified payment policy regarding teaching physicians in academic settings. These rules were published in the Federal Register on December 8, 1995, and will become effective July 1, 1996. An educational period will take place for the first six months of 1996.

In general, a teaching physician must be physically present for a key portion of the time during the performance of the service or procedure for which payment is sought. The presence of the physician must be documented in the medical records. In the case of surgery, complex or dangerous procedures, the teaching physician must be present during all critical portions of the procedure and must be immediately available during the entire service. A physician may not be required to be available in two places simultaneously. For endoscopy procedures, the teaching physician must be present for viewing. For psychiatric services, the teaching physician would be considered to be "present" during each patient encounter if it is observed through visual devices (two-way mirror or video camera), and meets with the patient after the visit. For diagnostic radiology and other diagnostic services, payment is made for the interpretation if the physician either performs the interpretation, or reviews the resident's interpretation.

Exceptions to the physical presence rule will be made in residency programs which meet the following criteria:

1. Services are provided in a hospital outpatient department or ambulatory care center. (Patient care activities by residents in both sites must be included in determining intermediary payments to the hospital.)
2. Residents providing services for which payment is sought must have completed at least six months of their residency program.
3. The teaching physician may not supervise more than four residents at one time, and must be immediately available.
4. The residents must follow the same group of patients throughout the course of their residency program.
5. The range of services furnished by residents must include: acute care for undifferentiated problems or chronic care for ongoing conditions, coordination of care, and comprehensive care.
6. The care is included in the full time equivalency count used by the intermediary in making direct GME payments.
7. This exception applies only to low level E/M codes (level 1, 2 and 3). For higher level services and all invasive procedures, the teaching physician must be present.
8. All other Medicare Program restrictions apply (e.g., screening services).

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EDITORIAL

Too much of a good thing

As the person who has over-indulged at an all-you-can-eat buffet knows, too much of a good thing can create problems. The concept of managed care began with the admirable goals of emphasizing preventive medicine and curtailing medical costs. And some managed care plans have carried out those goals successfully, providing patients with quality, coordinated care that is still cost-effective. But good ideas can be carried to extremes, and that is what has happened with plan restrictions that compromise quality care.

Those restrictions limit patients' access to complete information, choice of physician, treatment options, length of hospital stay, ability to buy health services and privacy. As a result, some health care decisions are being made by parties other than the person most qualified to determine the course of care – the physician – and the individual most affected by that care – the patient.

A Los Angeles neurologist, for example, recommended that a brain-damaged patient undergo a muscle biopsy to help diagnose the extent of his condition, according to the Jan. 8 issue of Time. "I was told [by the HMO that] it was a mistake to tell the patient about a procedure before checking to see whether it was covered," the doctor said. "It was as if I was a store vendor and was only supposed to advertise the products we offered."

In Sacramento, Calif., where managed care penetration has risen from 50 percent

to 96 percent in 10 years, physicians worry that their contracts with HMOs and IPAs will be terminated if they communicate what might be perceived as criticism of a particular plan, reported the Oct. 23, 1995, issue of Medical Economics. One doctor said he believes that is precisely why his group practice was deselected from the second-largest HMO in the area.

That HMO was rated by the California Medical Association as the state's second-worst health plan based on the portion of revenues it spends on medical care, according to the article. Yet the HMO reported a net income of \$38.8 million for the fiscal quarter ending June 30, 1995, and in 1994 it gave its CEO a compensation package worth \$13.7 million.

To curb managed care problems in California, CMA has prompted the introduction of more than 80 bills into the state legislature – not to eliminate managed care but to temper some onerous practices. The CMA's president said that doctors in other regions of the country will soon find themselves in similar situations and urged legislative solutions before abuses occur.

That is one reason ISMS crafted the Managed Care Patient Rights Act, which has been filed in the Illinois House and Senate and is described in the feature story in this issue. The Act sets ground rules to balance patient rights with the other goals of managed care. Supporting a bill of rights for our patients now may keep them from being sold a bill of goods later. ■

PRESIDENT'S LETTER

Physicians must remain patient advocates

Raymond E. Hoffmann, MD



These plans have become the third person in the examination room. Not silent partners, they influence much of what happens there.

It used to be that when people became sick or were injured, they went to their physician and were treated. They didn't go to their insurance company, call a number for authorization or check a brochure to see if a certain physician or hospital could take care of them. Managed care has changed all that. Why is it so attractive when it's changing the rules so fast?

Managed care has done a lot of good in offering cost-effective, streamlined care for its patients. I personally have attended 15 years of board meetings to help run a managed care organization in Rockford and am a strong supporter of high-quality, physician-run managed care. The squeeze, however, is becoming too tight.

Employers expect managed care to stabilize the rising costs of medical care. So far it looks as if it has. Or is it just pushing care into the future, when it will be even more expensive?

Patients are interested in managed care because they have less paperwork, low out-of-pocket expenses, stable costs and, usually, streamlined care. But some patients have noticed that these plans look better when they're healthy than when they're sick.

Physicians are interested so they can join organizations to compete against larger plans. Or are they doing this at the eventual expense of their autonomy?

Hospitals are apparently interested so that they can finally practice medicine – or at least manage the physicians they now employ. Yet this arrangement is financially successful in only about one-sixth of the cases.

If managed care is so great, why are there warnings about its effects? Never before have we seen so many articles on gag rules, deselection, gatekeepers, denial of procedures, delayed referrals and administrators overriding professional decisions. The media increasingly focuses on the link between physician incomes and the provision of less care. What's going on?

It seems to me that managed care is indirect management of the health care received by patients. What is managed directly are the doctor and the physician-patient relationship. All these plans – whether they are HMOs, PPOs or even traditional indemnity insurance with strong utilization controls – have become the third person in the examination room. Not silent partners, they influence much of what happens there.

Over the years patients have developed rights. The most obvious right is access to quality health care in a timely fashion. They get to choose which physician they see, where their care is given and when they want to be seen. They have also come to demand the right to confidentiality, information about their care and health insurance, and access to the best attempt to cure their illnesses through the latest drugs and procedures. These freedoms are being eroded by managed care.

The most basic health care right for patients is to know that their physician is their advocate. To have trust in the care offered by a physician, they must know that we are there for them and we don't represent an insurance plan. We cannot be both the doc and the third person in the exam room.

Physicians who have to sit in the examination room and tell patients such terrible facts about their future as, "You have cancer," are different from bean counters who just look at the bottom line to pinch more pennies.

Physicians are obligated to make sure that any new contracts they enter do not give away this right of patient advocacy. After all, that is what makes the physician-patient relationship work. The Managed Care Patient Rights Act will solidify these eroding rights of patients. If physicians stop advocating for patients, both doctors and patients will have lost it all. ■

GUEST EDITORIAL

The spin doctors

By Nicholas Wade

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Most systems of medicine are based on theater. With leeches, acupuncture needles, vitamin pills or whatever stage prop is appropriate for the time and culture, the healer artfully evokes the patient's powers of self-suggestion, which are responsible for whatever healing may occur.

Western medicine operates on a different plane. For one thing, it has the most impressive props — expensive medicines, elaborate rituals and mysterious high-tech machines with a white-gowned cast to operate them. For another, it evokes the patient's autosuggestive powers all the more forcefully by pretending to ignore them. This mysterious gift of self-healing is cloaked with an anodyne label, the "placebo effect," and recognized only as a nuisance likely to confound clinical trials. But the placebo (Latin for "I will please") and its shadowy twin the nocebo ("I will harm") are much more than methodological problems: they lie at the heart of every interaction between doctor and patient.

How they work no one knows. But the brain rules the body in many subconscious ways, including its control of the body's major hormones and its subtle influence over the immune system. So it's possible that, in ways yet unknown, expectations about health or disease are sometimes translated into a bodily reaction that fulfills them.

The power of these effects is hard to overstate. A rule of thumb is that 30 percent of patients in the placebo half of a drug trial (i.e., those who unknowingly receive a dummy pill instead of the real thing) will experience an improvement in symptoms. But the proportion may be much higher. Just like real drugs, placebo pills can produce stronger effects in larger doses. Patients will report greater relief when given a larger pill or two dummy capsules instead of one.

Doctors' expectations also contribute to the awesome power of the placebo effect. In a study of tooth extractions, patients were given either a painkiller or sham drugs. Some dentists were assigned to give either drug, without knowing which, but other dentists knew they would be giving only sham drugs. The patients whose dentists thought they had at least a 50-50 chance of giving a painkiller suffered significantly less pain.

Presumably, doctors transmit their expectations to the patient through subtle cues, often without knowing they are doing so. For this reason, all properly designed drug trials are double blind, meaning that neither physician nor patient knows whether the proffered pill is real or fake. But given that both groups can often guess from the side effects, even this precaution may not always squelch the generation of expectancies.

Much less attention has been paid to the inverse of the placebo effect, the creation of expectancies that make people

worse. The nocebo effect has been demonstrated among psychology students at the University of California in Los Angeles. When warned they might get a headache from a mild electric current being passed through their heads, two-thirds reported they felt pain. Even after the students were told that, in fact, there had been no current, none declared that the headache, too, hadn't been real. "It is amazing how I could be made to really feel the headache," one student said.

Voodoo death, which occurs after a hex has been put on the victim, is perhaps an extreme example of the nocebo effect. Dr. Herbert Benson, a cardiologist at the Harvard Medical School, says the phenomenon is well attested and may happen when a person's belief that he is about to die activates an area in the brain that can cause heart arrhythmia.

The nocebo effect in medicine has not been much explored, no doubt because of the obvious problems in deliberately doing things to patients that make them worse. But an intriguing study was reported in the British Medical Journal by Dr. K. B. Thomas, who assigned patients to positive or negative encounters with himself.

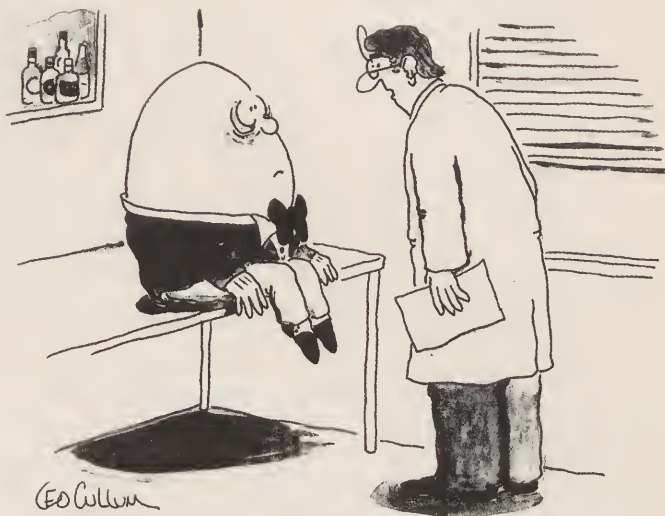
Dr. Thomas chose people with non-specific symptoms that tend to improve without any medical intervention. He gave one group a diagnosis and told the patients that they would be better in a few days. In what Dr. Thomas called a "negative consultation," he told the other patients that he did not know what was wrong with them. Two weeks later, some 65 percent of the patients in the first group recovered, but only 40 percent of the others were better.

Can words heal or kill? Are patients likely to do better if they are not told bad news? For doctors, the reporting of the truth is not a simple matter. An incautious word or unwarranted pessimism can make a patient depressed and less likely to do well.

Patients often say they have aches and pains when no organic illness can be found. A study of patients at a health maintenance organization concluded that more than half of all visits were made by the "worried well," people with no diagnosable disorder. Like the Pentagon analyst who said that he programmed "weapons that don't work against threats that don't exist," doctors must be sorely tempted to treat what seem to be imaginary diseases with imaginary remedies.

But to exploit the placebo effect by giving sweet talk and sugar pills puts the physician on the same plane as the voodoo doctor. It also leads down the course of guile and legerdemain. "In the current medical-legal climate, patient deception is not what you want people to do," says Dr. Judith A. Turner, a psychiatrist at the University of Washington in Seattle and co-author of a 1994 review of placebo effects in the Journal of the American Medical Association. "But there's nothing wrong in emphasizing positive treatments."

A physician must be careful about



"It's serious. You're pregnant."

every word he utters to a patient, says Dr. Ernst Wynder, from the American Health Foundation. He recently organized a conference on the nocebo effect. "My father, who was a doctor," he says, "knew every kid's name and the dog's name, but today medicine is very impersonal, and this all may contribute to the insecurity we have as individuals."

The game of expectations is played out in other settings besides the clinic. Nocebo effects can be contagious, as in the cases of mass hysteria that break out in schools and workplaces. "Beliefs can make us sick as well as healthy," wrote Robert Hahn, an epidemiologist at the Centers for Disease Control and Prevention, in a paper given at the nocebo con-

ference. "The nocebo phenomenon is a little-recognized facet of culture that may be responsible for a substantial variety of pathology throughout the world." Dr. Wynder suspects that complaints like those about breast implants and the Persian Gulf war syndrome may be derived partly from the nocebo effect, fanned by media coverage and the stimulus of damage awards.

Medical students invest heavily in learning medicine's scientific basis. They are committed to believing that the therapies they prescribe rest on rational principles. So they should. But patients can play both sides of the street. Given two equally competent physicians, pick the one with a smile and optimistic disposition. ■



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BY KATHN

All Americans receive certain basic protections against government intrusion through the Constitution's Bill of Rights. Today, Illinoisans need basic protections from managed care plan intrusion into the physician-patient relationship.

Evidence of the need for those protections has been widely documented: A gag clause in a managed care contract prohibits a physician from discussing follow-up therapy for a stroke patient because the insurer doesn't approve and won't pay for the expensive treatment. An insurer decides a patient should have outpatient surgery for endometriosis even though her doctor recommends an overnight stay because her multiple sclerosis increases the risk of postoperative problems. A baby develops life-threatening jaundice after he and his mother are discharged just 24 hours after his birth.

As managed care participation escalates in Illinois, so does the fear that quality is being sacrificed for cost in this new, profit-driven world of health care delivery. "We're very concerned that the cost-cutters are cutting quality," said ISMS President Raymond Hoffmann, MD. "It seems there often is a third person in the examining room. There's a doctor, a patient and an invisible third person directing the care. Managed care is not managing health care but [rather] managing the physician and the physician-patient relationship."

Hoping to reverse that trend, ISMS announced the introduction of the Managed Care Patient Rights Act at a Feb. 6 press conference in Springfield. The bill was filed the same day in the Illinois House of Representatives and Senate and has broad bipartisan support. Sponsors include Reps. Tom Cross (R-Yorkville), Kay Wojcik (R-Schaumburg), Judy Erwin (D-Chicago), Jeff Schoenberg (D-Wilmette) and John Turner (R-Lincoln); and Sens. Dan Cronin (R-Elmhurst), Doris Karpel (R-Roselle), Penny Severns (D-Decatur), Denny Jacobs (D-Moline) and James Clayborne (D-East St. Louis).

"Managed care consists of systems or techniques that are used to affect access to and control payments for health care services," the Act states. "As this state's health care market becomes increasingly dominated by managed care plans, it is a vital government function to protect patients and ensure fair and equitable managed care practices."

This proposed "bill of rights" for managed care patients says consumers should have timely access to high-quality medical care. Key to such care are the patients' rights to choose physicians, to get complete information about their condition and proposed treat-

ment, to receive a reasonable explanation of the total bill for health care services rendered, to be notified promptly about changes in coverage, to be guaranteed privacy and confidentiality, and to have access to non-covered health care services and out-of-plan providers if they personally cover the cost, according to the Act. "ISMS firmly believes these are fundamental rights to which all patients in managed care are entitled," said ISMS President-elect Sandra Olson, MD. "It is difficult to imagine that anyone interested in providing appropriate, high-quality medical care to patients in a timely fashion could argue against them."

Specifically, the ISMS-crafted bill says insurers that provide maternity benefits must pay for at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a cesarean-section delivery for both mother and baby. Also required are follow-up visits by a registered nurse within 48 hours of discharge. An attending physician must determine that minimum stays and follow-up visits are medically necessary, the Act states.

The Act also requires managed care plans to let their participants choose "any licensed physician participating in the plan" to coordinate their health care, prevents plans from using gag rules to "prohibit or discourage health care providers from discussing any alternative health care services and providers with enrollees," prevents insurers from rescinding or modifying treatment authorization "after the provider renders the health care service in good faith and pursuant to the authorization," requires plans to provide and pay for emergency care whether or not a participating provider performs the emergency services, and prohibits plans from retaliating against a health care provider who advocates for medically appropriate medical care for a patient by appealing a payer's decision to deny coverage.

"Sometimes, managed care restrains costs while maintaining – or even improving – the quality of care," Dr. Hoffmann said. "That can be a very good thing. But not all plans respect patients' rights. Only the law can make them do so. That's why Illinois needs the Managed Care Patient Rights Act – to define patient rights that every managed care plan must respect."

Many patients agree, according to legislators. "There has been an outcry from the constituency," said Wojcik. "They don't want their care managed. They want to make their own choices. When the president of the United States tried to put managed care [into his health care plan], it was not accepted. Now insurance companies are doing it. They say it is cost-

a bill of rights

managed care participants'
quality care.

URORE

effective, but it is hindering the patient's care. You don't have the personal touch you used to — that's the thing."

Wojcik knows from experience that managed care plans can be too cost-conscious and impersonal. Her granddaughter was born with cerebral palsy and needs expensive therapy. "What my children don't have to go through to get therapy for her!" she said. "Once you take up so much money for therapy, the plans don't want to pay for more."

"I've heard from [constituents] that they and their physicians need to be put back into the process [of managing their health care]," echoed Rep. Carolyn Krause (R-Mt. Prospect). "They have clearly seen that they're being dictated to, and their voices need to be heard. This legislation is very important and needed. It would address these concerns so we would have a more balanced managed care system."

One consumer concerned about managed care is Maureen Howard. In fact, she is the MS patient whose managed care plan would cover only outpatient surgery for endometriosis. She ultimately developed pneumonia and had to be hospitalized for 10 days.

"Just having a third party decide what is the best treatment for me is a problem," said Howard, a volunteer with the Greater Chicago and Illinois Chapter of the Multiple Sclerosis Foundation and a member of

its Governmental Affairs Council. "The ability to access specialists in the field of MS is really the most important thing because it is a unique disease. But a lot of managed care plans are trying to treat us with family physicians." And many plans won't cover the MRIs and other state-of-the-art diagnostic tests that offer a more definitive diagnosis of MS than was possible in the past. "It's almost as if we're going backward in time," Howard said. "I think [the MCPRA] will definitely help."

Cancer patients, too, are caught in the struggle between progressive medicine and managed care. As Nicholas Vogelzang, MD, president of the American Cancer Society, Illinois Division, said, "Patients in general in managed care programs have access to standard treatments. But they don't necessarily have access to investigational approaches. And standard treatments are difficult to define in cancer medicine."

Dr. Vogelzang also commented on an overall problem with managed care. "In the past the doctors had a financial interest to do tests and to make people better. Now we have doctors who have a financial interest [imposed by managed care plans] not to do tests and not to find out what's wrong with people. It's a new day, and it's a new world, and that's why we need this Managed Care Patient Rights Act." ■

Bill establishes patient rights

The Managed Care Patient Rights Act provides patients with the following basic rights:

- Quality health care services from the patient's health insurance plan,
- Freedom of choice of physician to coordinate health care,
- Confidence that the patient's health care providers are free to advocate on his or her behalf for medically necessary health care,
- Clear and understandable information about the terms and conditions of managed care plans and health insurance,
- Information on managed care plan performance in providing quality care,
- Mandatory minimum maternity benefits,
- Privacy and confidentiality in the use of health care services,
- Knowledge of the identity of the patient's participating providers,
- A reasonable explanation of the plan for the patient's care,
- A reasonable explanation of bills for services,
- Freedom to purchase necessary health care services,
- Protection from revocation of managed care authorization given in advance of the patient's treatment,
- Prohibition of prior authorization requirements for emergency care,
- Timely and clear notification when the patient's managed care plan terminates the patient's coverage or terminates the patient's provider from the plan.

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ISMIE Update

ISMIE seminar addresses risk reduction in managed care

ISSUES: Speakers discuss the importance of communication and record-keeping, and the risk management aspects of managed care. BY KATHLEEN FURORÉ

[CHICAGO] Medical malpractice cases often don't involve medical negligence. Yet they're lost "because of the risks physicians get themselves into," said Alfred Clementi, MD, chairman of the ISMIS Board of Directors, at an ISMIE seminar held Jan. 21 during the Chicago Medical Society's 1996 Midwest Clinical Conference in Chicago. Those risks often stem from communication and documentation problems and can be exacerbated in managed care settings, he noted.

With managed care, "we do not have a contract today with patients as we have in the past, but we have a written contract with insurance companies, even though we're still responsible for those patients," Dr. Clementi said. "With HMOs and PPOs the goal has always been to provide the best service for the least cost. But the goal of physicians has always been to diagnose and treat patients using the best medical science and at the same time limiting liability." Meeting the needs of patients and managed care organizations increases physicians' responsibility to

communicate better, from patient care and risk management perspectives, he explained. "We have to communicate with more people than we have in the past – not only patients but also gatekeepers as well as the [managed care entity]."

Keeping those lines of communication open – and thus minimizing risk – can be more difficult for physicians in managed care than those in fee-for-service situations. But it is imperative, Dr. Clementi said. The primary care physician in a managed care situation, for example, might never have seen or been contacted about a patient who presents in the emergency room. In the past, a physician who had not seen or been consulted about a patient would have had no responsibility for that patient's care. "But if that physician is in managed care and receives compensation for the care of that patient, he or she is involved," Dr. Clementi stressed. "The physician will get reports back on what was done in the way of testing and needs to have a close follow-up process. And if in fact he or she



Dr. Clementi

was called, the responsibility begins to build. In the managed care arena, there is more of a responsibility because of the gatekeeper situation."

Physicians also expose themselves to risk if they don't appeal managed care decisions that contradict what they consider to be the best medical treatment for patients and if they don't communicate their recommendations to patients. In *Wickline vs. The State of California*, for example, a physician requested an eight-day extension for a patient's hospital stay. The doctor did not object when the managed care entity approved only a

four-day extension. The patient ultimately developed gangrene, and her leg was amputated, Dr. Clementi said. "The appellate court warned the doctor that a physician who complies without protest to limits imposed by a third-party payer when medical judgment dictates otherwise cannot avoid ultimate responsibility for the patient's care. So you are responsible if you go along and don't protest."

"Once a particular physician begins to work with a patient, if the doctor is directed to change [the course of treatment] or if there's a denial by the gatekeeper, the physician must explain to the patient that this is contrary to his or her direction," he continued. "It's important to say, 'I would have liked to have done x or y or z to you, but it has been denied.'" In such instances, physicians should evaluate and make sure they agree with the managed care plan's recommended alternative. "If not, there is a serious problem. The physician must decide if he or she can continue to work with the patient in this particular [situation]," Dr. Clementi said.

Some managed care plans, however, may be "very, very unhappy" when physicians try to communicate such information to patients, he explained. Some even use contractual gag clauses that prevent doctors from providing such information.

Physicians should make sure they thoroughly read managed care contracts. They should beware of provisions that let the insurer change the agreement without notice and hold-harmless clauses that make the physician, not the HMO, responsible for any liability action that occurs. Doctors should also make sure there are processes for appealing denials of care and for questioning termination from the plan, Dr. Clementi said.

Jere Freidheim, MD, chairman of ISMIE's Risk Management Committee, who also spoke at the seminar, noted that

good communication is an essential risk management tool. "Effective communication helps improve doctor-patient rapport, increases patient satisfaction and prevents and manages adverse outcomes." Some 12 percent of ISMIE claims arise because of a personality conflict between the patient and physician, he noted.

After conference attendees watched a videotape presentation showing physicians using good and bad communication techniques, Dr. Freidheim discussed ways doctors can improve their communication skills. He suggested summarizing what a patient has said, asking the patient to paraphrase what you have said and providing written discharge and treatment instructions that explain the potential side effects and complications of a prescribed medication or treatment.

Attorney Kevin Glenn ended the session with a discussion of record-keeping. "A doctor virtually has no control over getting sued. And [the defense] doesn't have much input into the jury selection or control over the plaintiff's case. The only real control we have prior to suit are good records." Thorough, accurate documentation demonstrates the care a physician gave and can intimidate plaintiffs. "Good records can convince a reviewing doctor, and the plaintiff's attorney as well, that there really is no case."

He recommended that physicians dictate their notes, since "most of us talk more completely than we write," and use handouts that detail the information provided to patients, especially in informed consent conferences. "If you can say, 'It is my custom and practice to give this [form], we've won the informed consent battle.'"

Glenn also advised doctors to document conversations with their patients. "Ask, 'Do you understand what I just said?' and get feedback from the patient. If they missed something or left something out, you have the opportunity to reinforce [that information]. And note in the record, 'Patient expressed back to me his or her understanding.' The plaintiff's attorney has to overcome the power of that proof."

MALPRACTICE ROUNDUP

Two cases raise issue of HIV/AIDS diagnosis

Two cases raise the issue of physician liability stemming from the diagnosis of HIV and AIDS.

A \$9.1 million lawsuit filed in a Texas federal court alleged that a community health center, two other facilities and seven health care providers were negligent in their HIV diagnosis of Robert Swinea, reported the June 1995 issue of Medical Liability Advisory Service. Swinea alleged that he was never tested for the virus before being diagnosed as HIV-positive in July 1992. After the diagnosis, he began taking AZT and seven other medications.

Swinea said he became depressed, attempted suicide and was forced to discontinue his chiropractic studies. Two years later he discovered he was HIV-negative when he consulted another physician. He is seeking \$250,000 for extreme pain and suffering, \$333,000 for mental anguish and \$333,000 in punitive damages from each of the 10 defendants, according to the article.

In another case, physicians alleged to have been negligent for failing to diagnose and treat a patient with AIDS were found not liable, according to the ruling in *Morton vs. Mutchnick*.

The court of appeals in Missouri based its ruling on the theory that the patient lost no chance to recover from the illness because there is no cure for the disease, reported the November 1995 issue of Medical Liability Advisory Service. The court also ruled that the patient's parents could not recover damages in their wrongful death action because the alleged facts failed to state that if the physicians had not been negligent, the patient would not have died. ■

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CMS conference

(Continued from page 1)

the changing marketplace and the trend toward capitation while maintaining its long-standing advocacy role for all ISMS members, said Dr. Traugott, who, along with ISMS Immediate Past President Alan Roman, MD, co-chaired the committee that recommended the PSO.

Physicians shouldn't jump into managed care and capitation without a solid foundation, Dr. Traugott said. "The PSO will create a foundation and assist those physicians who choose to participate in this new type of payment arrangement." The PSO, unlike other management services organizations in Illinois, will be physician-designed and physician-directed, he explained. "ISMS holds a tremendous opportunity to define the future health care delivery system for Illinois physicians and their patients. The most exciting part is that the PSO will make it possible for those willing to participate in risk-bearing programs to do so successfully."

Ray discussed issues facing physicians as they try to assert control in the managed care arena. "Capitation thrusts a provider organization into the insurance business. But it is even more complicated, since insurance management techniques must be integrated with care giving and care management."

"Profit is the reward for taking risk, however," Ray continued. "The managed care organizations with the longest track record of success are those that aren't

contract organizations but providers that sell health care to employers. That's where the long-term success has been — doctors working together in an organized fashion to deliver value to those who purchase care." Those who buy care, in fact, are beginning to do more direct contracting with organized health care providers, he said. "Purchasers of health care are growing uneasy with the lack of value offered by the large HMOs."

One physician who seized the reins of change is Dr. Downey, who joined more than 60 other primary care physicians to form the Evanston-Glenbrook Physicians Association in 1993. "Several years ago riding a horse and holding the reins were things I and my partners hadn't thought about," he said. "We hadn't considered forming an IPA before. But it

became apparent that what was happening in California was going to come this way before too long, and we thought we should form something ourselves before something was forced upon us."

The physicians in Dr. Downey's group first considered forming a physician hospital organization. "But we decided a PHO was not the way for us to go," he said. "There is no question that the control of the PHO would have been in the hands of the hospital. The hospital had all the money, and we just had the doctors. We had to have capital."

To raise that capital and ultimately retain control, each founding member of the IPA contributed a small sum of money and signed onto a line of credit, which the group never had to fully tap, Dr. Downey said. The group started seeing

"a few managed care patients" in October 1994 and had grown fivefold by January 1996, he added.

Minnesota physicians have retained control of health care delivery so successfully that "doctors and hospitals are asking to be capitated," Dr. Halaas said. The benefits of such a system are that prepayment offers financial advantages; doctors can manage the total health care dollar; barriers to care are lowered because of the emphasis on preventive care; and care can be improved because physicians within a system share information about the treatments and protocols that have worked best for their patients.

"We think of managed care as managed health," she said. "It puts more control for health care outcomes in physicians' hands."

ISMS' patient rights

(Continued from page 1)

AMA President Lonnie Bristow, MD. "We will do whatever it takes to provide the best possible care for our patients. If that means referring patients to physicians outside their plans or telling patients about treatments their plans don't cover, so be it. Patients are our foremost responsibility. Their needs come before our needs and the needs of managed care plans."

From a liability perspective, physicians might be held responsible if they followed gag rules by not telling patients

about treatment options they thought would be beneficial and if those patients filed suit. "You're taking a huge liability risk if you don't tell a patient about a treatment you recommended," said ISMS General Counsel Saul Morse.

Unless such legislation as MCPRA passes, physicians whose contracts include gag clauses should make sure they understand and use the managed care plan's internal appeal process for decisions they consider inappropriate, according to Morse. "Make sure you do what is medically appropriate on behalf of the patient," he said. "Physicians have an ethical and legal obligation to treat their patients in a way that is best for the

patient. They should always bear in mind their responsibility to give honest and full advice."

The AMA is calling on all physicians to provide patients with "all relevant information regarding treatment alternatives, regardless of the provisions or limitations of health plans." The organization will support physicians who think a gag clause or similar policy is preventing them from fulfilling their ethical duties.

ISMS members may also contact the Society's Lawyer Referral Network for a referral to an attorney who can advise them on managed care contracts. For more information, call (800) MD-ASIST.

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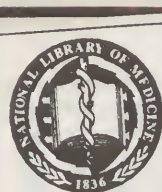
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Applying the
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plastic surgery

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ISMS announces patient 'bill of rights'

ADVOCACY: Dr. Hoffmann announces legislation to help maintain quality in patient care. BY MARY NOLAN

[SPRINGFIELD] Patient rights are the cornerstone of the Managed Care Patient Rights Act, comprehensive legislation that was announced at a news conference on Feb. 6 at the State Capitol in Springfield and was introduced into the Illinois House and Senate the same day.

patients' and physicians' answers to this vital public health issue," Dr. Hoffmann said. "It's called the Managed Care Patient Rights Act. This act will balance the needs of patients with the interests of insurance companies that we all use to finance our health care. In this increasingly competitive marketplace, driven more and more by profit motives, we need firm ground rules that spell out patient rights for every plan."

Dr. Hoffmann outlined the specific problems the bill addresses: "We've all heard stories of denial of access to specialists and to treatments. We've all heard stories of drive-through delivery. We need to make sure there are minimum maternity benefits, there is no telephone call that has to be made before somebody goes to an emergency room for a true emergency. We want to make sure that if preauthorized care was given, all of a sudden [that] authorization won't be withdrawn." The bill also ensures that patients know how a plan and payments to providers are structured, "so patients can truly decide whether or not their [providers are] act-



Sen. Cronin



Ron Ackerman

Some of the sponsors attending ISMS' news conference were Reps. Schoenberg (left to right), Cross and Erwin, and Sens. Sevens and Karpel. Dr. Hoffmann (back, center) represented ISMS. Also attending were Sens. Jacobs and Clayborne and Rep. Turner.

ing in their best interest."

To illustrate the problem with practices like the use of contractual gag rules, Dr. Hoffmann cited the Time magazine article about the breast cancer patient seeking a bone marrow transplant. One of her physicians

refused to talk to her about what was involved in the transplant procedure. "I think it's un-American not to let people talk freely. In addition, when you're dealing with the health care of patients, you must consider all options

(Continued on page 14)



Dr. Hoffmann

ISMS President Raymond Hoffmann, MD, and the bipartisan sponsors of the bill called on the Illinois General Assembly to take a leadership role in setting guidelines to protect managed care patients from plan practices that compromise the quality of patient care because of financial concerns.

"Today, we present the



Jon McGinty

ISMS PAST PRESIDENT Arthur Traugott, MD (left), speaks to physicians about the Society's planned Physician Services Organization at a Jan. 24 workshop in Champaign, as Eighth District trustee Nestor Ramirez, MD, listens.

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HCFA implements new Medicare coding policy

UPDATE: Revised system will catch errors that cause inappropriate reimbursements for Part B claims. BY KATHLEEN FURORE

[WASHINGTON] The U.S. Health Care Financing Administration has revised its Correct Coding Policy to catch coding errors that lead to excessive reimbursements for Part B claims. To help implement the new policy, Medicare carriers nationwide are using an enhanced computerized claims processing system that identifies some 84,000 inappropriate code pairs, according to HCFA CPT coding specialist Mary Cooper. Previously, the system contained only 200 inappropriate code pairs, she said.

The updated system automatically flags claims submitted with inappropriate codes and rejects them or changes them to reflect a more appropriate code and reduces the reimbursement. The coding initiative is currently focusing on comprehensive and

component code combinations, and mutually exclusive coding combinations, Cooper said.

Under the updated coding policy, physicians who submit a comprehensive procedure code to Medicare must have performed all the services included in the description of the procedure. And they can't "unbundle" codes by submitting claims for component parts of a comprehensive service or procedure in addition to submitting the comprehensive code. A total hysterectomy, for example, is a comprehensive service involving

removal of the ovaries and tubes. Consequently, a doctor can't also submit separate codes for removal of the ovaries and for removal of the tubes, Cooper explained.

Based on the CPT definition for standard medical practice, doctors are also prohibited from concurrently submitting claims for services or procedures that would not or could not reasonably be performed at the same session by the same provider on the same patient. "There are various approaches used to

(Continued on page 14)

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Didrickson speaks to women health executives

PROGRAM: The state comptroller discusses the present and future of Medicaid. BY JANICE ROSENBERG

[CHICAGO] Over the past two fiscal years, Illinois has reduced the amount of time physicians and other providers wait for Medicaid reimbursement from 180 days to about 45, said Loleta Didrickson, state comptroller, at a Jan. 31 meeting of the Women Health Executives Network in Chicago.

In addition, the state has chipped away at the Medicaid deficit because of an appropriation increase by the General Assembly and growth in the state's revenue base, she said. "We're making progress, but we haven't gotten the job done yet."

According to Dean Schott, Illinois Department of Public Aid spokesperson, some \$434.4 million in medical liabilities remained unpaid in early February.

Over the last 10 years, state Medicaid costs have risen considerably, Didrickson said. In 1985, Illinois spent \$1.7 billion on Medicaid. The appropriation for 1996 is \$5.5 billion, or 25 percent of the state's entire general funds appropriation. Contributing to the rise in Medicaid costs were a 10.4 percent annual growth in the state's elderly population from 1991 to 1994 and that population's increased need for long-term care, she said.

Enabling more Medicaid recipients to choose managed care coverage under the state's proposed MediPlan Plus program would result in considerable cost savings, Didrickson said. Recipients would, however, still have the option of fee-for-service care.

Before MediPlan Plus can be implemented, IDPA must be granted a waiver by the U.S. Health Care Financing Administration. The waiver would allow Medicaid patients to choose their providers but would lock them into those choices for a full 12 months. Under federal law, those selections can be locked in for only six months. The waiver would also allow the state to develop Managed Care Community Networks to serve a 100-percent Medicaid client base. Under federal rules, HMOs cannot exceed 75 percent Medicaid enrollment.

Currently, 170,000 Medicaid patients are enrolled in HMOs – about a 40 percent increase over last year's number, according to Schott. The state and HCFA are still negotiating the final terms and conditions of the waiver, he said, adding



Didrickson

that the two sides are close.

"With or without Medicaid reform or the waiver, our intention is to pursue more managed care for the Medicaid system in Illinois," Schott said. "Federal medical reform in the Republican version of the plan would certainly give us more impetus to achieve that goal."

Didrickson, too, said managed care is inevitable in conjunction with the transference of federal programs to the states. Managing Medicaid without overregulation from Washington would allow Illinois to be more efficient and more accountable, she said.

If and when the administration of Medicaid is turned over to the state, Illinois will have to invest in the infrastructure to run the program, Didrickson noted. "We will have to spend, but streamlining will give us a return on our investment that we can put back into programs and services."

HCFA clarifies payment for teaching physicians

[WASHINGTON] The U.S. Health Care Financing Administration has issued rules regarding the payment of teaching physicians in academic settings. They will become effective July 1, following an educational period during the first six months of 1996.

To be paid for a service or procedure, teaching physicians must be physically present for a key portion of the time the service is performed, and their presence must be documented in the medical records, according to the rules. They must be present during all critical portions of surgery and complex or dangerous procedures, and they must be immediately available during the entire service.

For endoscopy procedures, teaching physicians must be present for viewing. Teaching physicians are considered present for psychiatric services if they observe patient encounters through two-way mirrors or a video camera and if they meet with patients after the visits. For diagnostic radiology and other diagnostic services, payment is made for interpretations if physicians either perform the interpretations or review the residents' interpretations.

Exceptions to the physical presence rule will be made in residency programs that meet the following criteria:

- Services must be provided in a hospital outpatient department or ambulatory care center.
- Residents providing services for which payment is sought must have completed at least six months of their residency program.
- The teaching physician must not supervise more than four residents simultaneously and must be immediately available.
- The residents must follow the same group of patients throughout the course of their residency program.
- The range of services furnished by residents must include acute care for undifferentiated problems or chronic care for ongoing conditions, coordination of care and comprehensive care.
- The care must be included in the full-time equivalency count used by the intermediary in making direct GME payments.
- Exceptions apply only to level 1, 2 and 3 evaluation/management codes for office visits, consultations and hospital inpatient visits.
- All other Medicare program restrictions apply.

Physicians who have questions about the criteria should contact their carrier. ■



The Photo Partners/Wm. Daniels

ILLINOIS Lt. Gov. Bob Kustra, Republican candidate for the U.S. Senate, spoke at a Feb. 3 meeting of the ISMS Board of Trustees in Chicago. He talked about the need for tort reform at the federal level and protection for managed care patients.

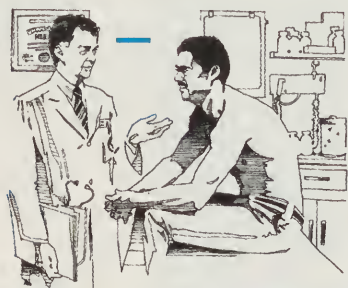
Center for young Parkinson patients moves to Illinois

[GLENVIEW] The Young Parkinson Information and Referral Center, established by the American Parkinson Disease Association, has relocated from California to the Glenbrook Hospital in Glenview. The center provides information about the disease and assists young patients in finding or starting support groups.

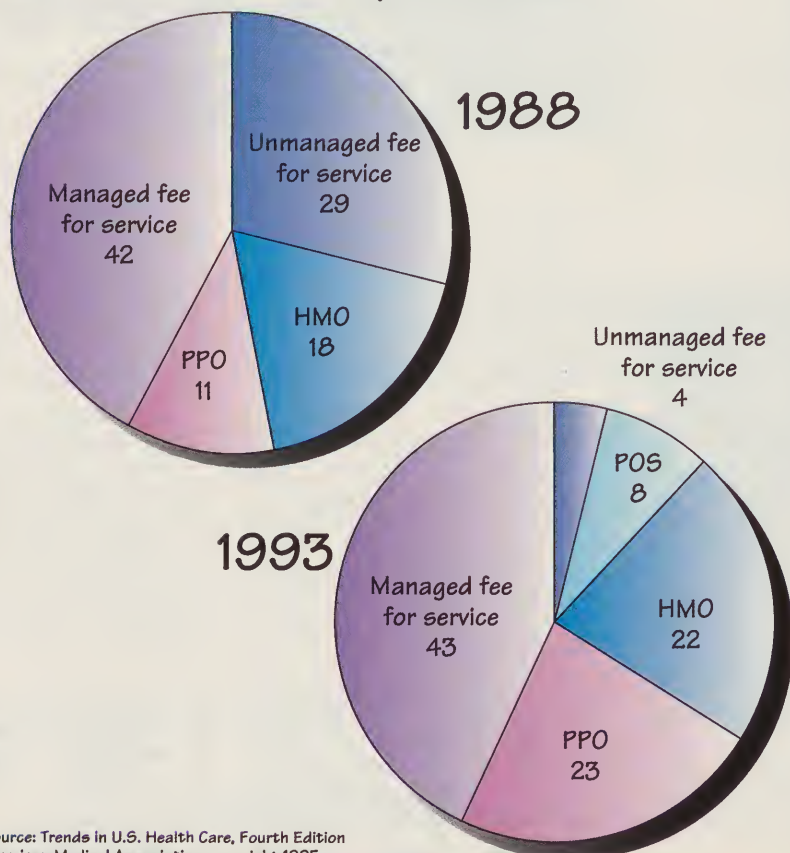
The number of young people being diagnosed with the disease is increasing, according to the hospital, with 10 percent of Parkinson patients between the ages of 30 and 50. These patients have unique needs – for example, for employment, help in raising families and long-term financial planning – that may not be met through programs that primarily serve the older population of Parkinson patients, noted Susan Reese, director of the program at Glenbrook.

Services provided by the program include a nationwide support network of young Parkinson patients, support group referrals for family members and caregivers, free information booklets, a newsletter and a computer bulletin board with related information.

The center can be reached at (847) 657-5787 or (800) 223-9776. ■



Managed care market share (percentage)



Source: Trends in U.S. Health Care, Fourth Edition American Medical Association, copyright 1995

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Legislation signed into law

ROUNDUP: Gov. Edgar acts on health care-related bills.

BY MARY NOLAN

[SPRINGFIELD] During the fall 1995 veto session, Gov. Jim Edgar acted on several health care-related bills, including the following.

Optical imaging ok'd

H.B. 1868 amends the Illinois Insurance Code and permits insurers to use optically scanned copies of their books, records and other documents as original copies. This measure, sponsored by Rep. Tom Cross (R-Yorkville) and Sen. Robert Raica (R-LaGrange), allows any original copies to be destroyed if they have been recorded through optical imaging.

Such imaging refers to the filmed reproduction of any writing or record through any photographic, photostatic, microfilm, microcard, miniature photographic or other, similar process.

"Optical imaging is already permitted in other areas of the law that relate to the copying of documents," wrote ISMS Chairman of the Board of Trustees Ronald G. Welch, MD, in a letter urging Edgar to sign the bill. "Allowing this type of imaging will improve storage capabilities for insurance companies and reduce the cost of doing business for the state's insurers." Gov. Edgar signed the measure on Dec. 15, following the fall veto session.

Physician liability limited

Edgar also signed a bill limiting the liability of physicians and other health care providers who rely on decisions or directions made by guardians, standby guardians or short-term guardians. The measure, S.B. 79, was sponsored by Sen. Peter Fitzgerald (R-Palatine) and Rep. John Turner (R-Lincoln).

In a letter to the governor, Dr. Welch wrote, "This protection is the same [as that] provided to health care providers when responding to requests of surrogates under the Illinois Health Care Surrogate Act and similar to protection provided for health care providers relying upon Durable Powers of Attorney for Health Care."

Physicians and health care providers who rely on and carry out the guardians' instructions with proper care are not subject to any claim based on the lack of parental consent or to criminal prosecution or to discipline for unprofessional conduct. The legislation does not, however, protect them from liability for their own negligence when performing duties or carrying out instructions.

Mental health review board

Under a bill signed into law on Dec. 7, the number of physician specialists in psychiatry and primary care who constitute the Mental Health and Developmental Disabilities Medical Review Board was reduced from 15 to five members.

"We believe that this change will make the board a more effective body in carrying out its duties to aid in the investigation of abuse and deaths that may occur within the state's mental health facilities," wrote Dr. Welch.

In addition to reducing the number of board members, the measure, S.B. 388, clarifies nurses' performance of certain tasks related to the administration of psychotropic medication. Those tasks must be completed under physician

supervision, according to the legislation. "While this is a standard practice, this new language in the law will avoid misinterpretations or ambiguities that sometimes arise," Dr. Welch stated in a letter to Edgar.

The measure, sponsored by Sen. Aldo DeAngelis (R-Chicago Heights) and Rep. Ann Hughes (R-McHenry), also revises

the powers and duties of the inspector general in the Illinois Department of Mental Health and Developmental Disabilities. The inspector general is now required to investigate reports of suspected abuse or neglect and to take immediate action on those reports regardless of whether the patients involved are in a state-owned facility or program. The inspector general must also promulgate rules establishing minimum requirements for initiating, conducting and completing investigations. ISMS supported the legislation.

Student loan repayment

On Nov. 17, Edgar signed S.B. 442,

which provides that if the Illinois Department of Professional Regulation determines that a license holder failed to make satisfactory repayment to the Illinois Student Assistance Commission for a delinquent or defaulted loan, IDPR can suspend or revoke that individual's license at any time instead of only during the renewal stage. The law applies to licensed professionals including physicians.

ISMS supported an amendment that was included in the new legislation. The provision grants license holders such due process protections as a hearing in all cases of license nonrenewal.

(Continued on page 13)



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REPORT for Illinois Physicians

THE EFFECTIVE USE OF 23-HOUR OBSERVATION UNITS

The Health Care Industry continues to respond to increasing challenges to deliver high quality care in the most cost-effective and efficient manner. One approach of hospitals has been the development of 23-hour observation units, or the management of patients on a 23-hour observation status on any floor in a hospital. These 23-hour observation approaches are intended to be a less costly alternative to a regular hospitalization.

Usually, management of patients in a 23-hour observation unit is indicated for clinical conditions that require urgent evaluation and treatment in a hospital setting that provides the ancillary, medical, and skilled nursing services that are necessary for diagnosing and/or treating the presenting condition. However in these cases it should be the clinical impression that full in-patient admission will not be necessary, and that prompt initiation of diagnostic evaluation and/or short-term treatment in the observation setting will resolve or stabilize the presenting condition within 23-hours, obviating the need for full admission. Obviously, if it is the clinical belief of the attending physician that full admission will be necessary, then the patient should be directly admitted to the hospital.

The 23-hour observation unit provides an excellent cost-effective alternative to pre-op day admissions, and to hospitalization for certain acute medical conditions. Some examples would be:

- Pre-op colon preparation in selected patients
 - mentally incompetent and/or physically disabled patients who require extensive colon preparation
 - Patients with moderate to severe intestinal obstruction symptoms that prevent oral hydration and complicate outpatient colon preparation
- Sickle cell pain crisis
- Acute exacerbation of bronchial asthma
- Patients with chest pain with a low probability for acute myocardial infarction¹
- Pain management
- I.V. rehydration

Utilization of 23-hour observation units for care that can properly be provided in an out-patient setting is not appropriate.

Some examples of inappropriate use of the 23-hour observations unit would be:

- Preoperative care for elective surgery
- Outpatient surgery or procedures that are usually associated with uncomplicated recovery periods
- Use of the 23-hour observation unit for the convenience of patient, physician, family or the hospital

Physicians should remember that hospitals vary greatly in their charge amounts and patterns. In many situations, a prolonged stay in a 23-hour observation unit may be more costly than a short full in-patient admission. Furthermore, a prolonged period of observation followed by an in-patient admission is usually also not cost-effective. Therefore, physicians should become aware of the charging mechanisms of the hospitals in which they practice, so that the physician can make the most appropriate and cost effective decision regarding the use of a 23-hour observation unit.

¹ Outcome of patients who were admitted to a New Short-Stay Unit to "Rule-Out" Myocardial Infarction. Ame. J. Cardiology; July 15, 1991; Vol 68, No. 2.

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EDITORIAL

Patients deserve basic rights

A recent cartoon in the St. Louis Post-Dispatch shows a gigantic man in a suit labeled "the insurance industry" shoving a physician behind him while he says to a patient, "Surely you don't want some big government bureaucracy telling you how to handle your health care!"

ISMS' Managed Care Patient Rights Act aims to avoid such potential realities by keeping basic rights where they belong - with managed care patients. Those rights would enable patients to receive quality care, to be informed about that care and the bill for it, to learn about any changes in coverage in a timely way, to be assured of privacy and confidentiality, and to buy extra health care services with their own money.

The day after the bill was announced at an ISMS news conference and filed in the Illinois House and Senate, some opponents accused the measure of attempting to sabotage the managed care industry and make managed care so expensive that it can't work. Nothing could be further from the truth.

Some managed care plans can and do provide patients with quality care that is also cost-effective. For one thing, they invest a substantial amount of revenues in patient care. In 1995, for example, HMO Kaiser Permanente spent 97 percent of its revenues on patient care, according to a recent study conducted by the California Medical Association and reported in the San Francisco Examiner.

But CaliforniaCare, the state's largest for-profit HMO, spent only 73 percent on medical care, with 27 percent going for overhead. And Foundation Health, another major California HMO, spent just 77 percent on patient care and 23 percent on overhead.

A think tank that wasn't involved in the CMA study said HMOs may be top-heavy if their overhead costs exceed 20 percent of their revenue, according to the study. A physician interviewed by the Examiner asked, "Would you go to a stockbroker or financial manager who took 25 cents out of every dollar you invested? Patients might ask, 'Why aren't my premiums lower?'"

The allegations about cost may be an attempt to divert attention from the true issues of quality of care and the preservation of the physician-patient relationship. ISMS' patient rights act would foster that relationship by granting the basic rights mentioned previously and prohibiting contractual gag rules.

In Massachusetts, the nation's first law outlawing HMO gag clauses was recently passed. The president of the Massachusetts Medical Society called gag rules a "true violation of the physician-patient relationship" and said physicians now will "no longer fear retaliation" for being patient advocates, according to Physician's Weekly.

Contact your legislators and express your support for MCPRA. Let's help Illinois follow Massachusetts' example. ■

PRESIDENT'S LETTER

How ISMS resolutions became MCPRA

Raymond E. Hoffmann, MD



An unexpected part of my presidency was the opportunity to present and defend this vital piece of legislation.

It's interesting how much democracy you can see in action as president of a medical society. Before I began my term as president, I knew that my main responsibilities would be giving media interviews and speeches and representing ISMS to our members and the outside world. On Feb. 6, I had the opportunity to handle the press conference at which we introduced the Managed Care Patient Rights Act. Once again, I felt a part of the democratic process we hold so dear in this country.

As I've spoken to members and civic groups around the state, a few of the issues hounding me have been "drive-through deliveries," precertification for emergency room visits, "point of service" and economic credentialing. Legislators had introduced bills to address some of these matters, but none of the proposals were inclusive enough.

Changes to anything as individual and precious as health care are bound to evoke a sense of great apprehension. I'm sure our predecessors felt the same way years ago when Medicare started. Managed care is changing many things for the better, as Medicare did previously. Just the worry about change gets to us, though.

ISMS officers and staff have noted those concerns voiced by member questions and letters. A growing cacophony of questions in media articles and news programs has added to the sense of urgency. A recent Time magazine article, for example, was inspired by the California HMO that appeared to use gag clauses to limit physicians' freedom of professional decision-making and their ability to discuss appropriate treatment options with patients.

Over the last few years, resolutions from the House of Delegates have dealt with many of these same issues. So staff in the legal, public relations and governmental affairs departments looked at those resolutions and, along with the chairman of the Board of Trustees,

developed a bill. This bill had to include more than just resolutions, since new issues have arisen. The abuse of patients' rights was the common thread, and so the Managed Care Patient Rights Act was born. Then the board fine-tuned the bill before giving it final approval.

Next came efforts to ensure this bill would interest the public and would be presented in such a way that they would get behind it. A video substantiating the need for the measure was made to help present some of our patients' stories.

Your president and president-elect spent many hours learning the nuances of the bill to be able to present it most effectively to the public.

Ultimately came the press conference. This was the culmination of years of annual meetings of the House of Delegates, weeks of staff work to write the bill, days of strategy meetings, hours of media preparation and, finally, minutes of anxiety before the conference started.

Fortunately, it was a slow news day, so there wasn't much competition. Unfortunately, it was a slow news day, and all the media showed up to talk about MCPRA and ask questions. The conference focused on our message: We are not going to sacrifice quality of care for our patients just to save money in this new environment.

So that is what happens to resolutions introduced into the ISMS House of Delegates. They percolate along until they are hot enough topics to warrant legislative action. Officers and staff mold them into a package for presentation to the public and legislators. The full legislative process shapes them into law.

An unexpected part of my presidency was the opportunity to present and defend this vital piece of legislation. I have again seen democracy in action. There cannot be a better system than to take ideas from resolutions and make them law. ■

GUEST EDITORIAL

Docs need to question HMOs

By Joan Beck

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It's scary that physicians are rapidly losing so much of the control they have had over the nation's health care system. By the tens of thousands they are signing away their professional independence – and in some instances the health of their patients – for an HMO paycheck and HMO rules about how they must practice medicine to make profits for stockholders and administrators.

Even Hillary Rodham Clinton, who tried to push most Americans into managed care organizations as part of her defeated health care package in 1994, is alarmed about what's going on now as market forces in medicine change so fast.

She wrote me a letter after a recent column on health care, saying, "Your column and the New England Journal of Medicine article expose the real pressures and incentives that are developing in some managed care companies."

"I share your fear that these changes are compromising the ability of patients to choose their own doctor and of physicians to exercise their professional judgment."

"What is at stake is nothing less than the highest medical care in the world and the health of our parents and children."

Now, the accelerating changes in health care – pushed by political and economic forces, not medical reasons – are beginning to hit doctors in their bank accounts.

The median net income for physicians dropped 3.8 percent in 1994, according to a new survey by the American Medical Association. It's the first decrease ever recorded by the AMA.

Physicians had a median income of \$150,000 after practice expenses and before taxes in 1994, a decline from \$156,000 in 1993. Fourteen categories of doctors lost income, six stayed the same, and only one, orthopedic surgeons, saw an increase, a negligible 0.7 percent.

Specialists in cardiovascular disease took a 12 percent hit, down to \$220,000. Otolaryngologists dropped 11.1 percent to \$225,000, and pathologists had a 10.6 percent loss to a median of \$152,000. Radiologists had a \$220,000 median income, an 8.3 percent decrease from 1993. The incomes of general family physicians, internists and psychiatrists remained about the same.

The cutbacks come after a decade of rising income. Between 1984 and 1994, pay for doctors increased an average of 5 percent a year, compared to an average annual inflation rate of 3.6 percent, according to the AMA.

The reasons doctors' incomes are slumping, says the AMA, is in part an increase in the expenses of running a practice, in part Medicare reimbursements, which have not increased, and in part the efforts by managed care organizations to hold down payments to physicians.

Even so, it's fear of losing income that is pushing thousands of physicians to sign up with managed care organizations. As millions more people are shoved into

HMOs by employers and insurers in efforts to control health care costs, many doctors worry that they will be left without enough patients unless they become HMO employees or contract with HMOs to see some of their clients.

What's alarming is that some HMOs not only give their doctors practice guidelines, but insist physicians follow them even if it means denying patients some expensive treatments, not discussing other treatment choices with patients and keeping hospitalization and referrals to specialists to a minimum. Most must let administrators (or clerks) override their professional decisions, in the interests of saving money.

And many managed care doctors agree to pay packages that give them financial incentives to do as little as possible for their patients.

Practice guidelines can be a good idea. Studies show physicians in different areas have widely varying rates for many medical procedures, such as hysterectomies and cesarean sections.

What is worrisome are the guidelines in some HMOs that are based more on the cost of procedures than sound research on outcomes. Or rules that restrict doctors from going outside the guidelines when they think it is necessary in individual cases. Or that keep patients from seeing specialists who know more about their problems than the primary care "gatekeeper." Or that refuse to allow expensive procedures like bone marrow transplants on the grounds they are "experimental."

When an HMO ties its physicians' incomes directly to giving a minimal level of care, to cutting back on referrals to specialists, to reducing hospitalization and using only drugs on its prescribed list, then patients have good reason to worry. It is already becoming difficult for some patients to know whether they can trust their doctors.

But managed care organizations can't function without physicians. Doctors hold more power in the nation's health care system than they have been willing to exercise in this time of rapid and potentially dangerous organizational changes.

If physicians in large numbers refuse to sign restrictive and potentially harmful contracts, HMOs would have to change their worrisome practices. If employers took a closer look at the financial incentives and regulations in HMO contracts before they pushed employees into signing up and objected to those that could harm patients, there might be fewer problems. There would also be less need for scary news stories like Time's recent cover package on "What Your Doctor Can't Tell You."

There would be fewer malpractice suits – one of the few potential protections patients have. There would be less need for legislatures in 50 states to pass laws prescribing health care (like the bills insisting new mothers get two days in the hospital, not just one, after normal childbirth). And patients would have more confidence that their doctor was really their honest advocate. ■

LETTERS

Don't mince words

In the Jan. 19 issue of Illinois Medicine, "Malpractice Roundup" mentioned a case involving informed consent for what was described as laser therapy. Nowhere was the word surgery used, though it was obvious the procedure involved the surgical removal of a skin lesion with a laser.

As medical technology advances, patients clearly benefit from decreased invasiveness, faster recovery time and less discomfort during procedures. However, these benefits tend to cause patients to minimize the complexity of care and the skill required of physicians. This is a chal-

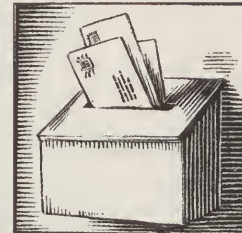
lenge we all need to keep in mind.

Perhaps we in ophthalmology are more attuned to these kinds of semantics. In Idaho and Oklahoma, for example, optometrists have already claimed the legislative right to perform laser surgery of the eye. Similar bills have been filed in two other states.

As physicians and surgeons, we do not help our patients by minimizing surgical procedures, especially when we shy away from using the proper terminology.

— John P. Hanlon, MD
Vernon Hills

Illinois Medicine reserves the right to edit all letters to the editor.



GUEST EDITORIAL

Catholic physician group concerned about patient rights

By William G. White, MD

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Last year the American people dodged the Clinton health care reform plan that threatened them with a bureaucratic monstrosity. Unfortunately, the monster is not dead but has been revived by the private sector in the form of managed care.

Managed care is essentially a form of collusion between big business, big insurance companies and big hospital conglomerates to take over medical decisions from patients and their personal physicians. This has been accomplished by making physicians agents of the company, rather than the patient.

Not all physicians have endorsed the principles of managed care, however. At its recent annual meeting, the National Federation of Catholic Physicians' Guilds resolved "that hospitals and physicians resist any form of payment plan that compromises the right of patients and the ethical standards of physicians and hospitals." The federation noted several disturbing features of managed care, among which were that employees "are frequently given little or no choice of insurance plan, personal physician or hospital," and that "the confidentiality of patients' records is routinely violated, often under the guise of 'quality assurance.'"

The federation also observed that "pressure in the form of financial incentives and disincentives, as well as the threat of termination of contract, is placed upon physicians and hospitals to make medical decisions based on the financial well-being of corporations rather than on the personal needs of patients," and that "under capitation (payment for withholding care), both physicians and

hospitals are placed in a position of direct conflict of interest with patients."

The Catholic physicians' group was particularly concerned that "both physicians and hospitals are pressured to perform immoral procedures such as abortion, sterilization, contraception and the withholding of care from the elderly and the very ill, and that Catholic hospitals are pressured to enter into networks in which their standards of ethics are compromised."

Surely private insurance and private medicine have their faults, especially high cost, and physicians are not without blame. Real reforms are badly needed to rein in costs and to return medical decision-making and responsibility to the person most concerned: the patient. Medical saving accounts may prove to be a superior alternative to the present insurance system.

A hundred years ago, workers were essentially indentured to industries that tried to manage their entire lives. No one regrets the passing of the "company store" where workers were forced to purchase their daily needs at prices beyond their daily wages. As the old song said, "Sixteen tons and what do you get? Another day older and deeper in debt." Today corporations are downsizing, workers are being pressured to work harder and longer, and many are being forced into managed (rationed) medical care. Perhaps the old song needs an update: "Sixteen tons and what do you get? Another day older and no doctor yet." ■

Dr. White is chairman of the Committee on Steering and Resolutions of the National Federation of Catholic Physicians' Guilds.

Illinois Blues pursues merger with Texas Blues, acquisition of Dreyer in Aurora

AFFILIATION AGREEMENT: Illinois and Texas plans would have combined total of about 3.8 million subscribers. BY MARY NOLAN

[CHICAGO] Blue Cross and Blue Shield of Illinois is pursuing a merger and an acquisition that would extend its reach both inside and outside the state.

In late January, BCBSI and Blue Cross and Blue Shield of Texas reached an affiliation agreement marking the first step toward a full merger between the two groups, which are already among the strongest Blues in the nation.

Closer to home, BCBSI and Oak Brook-based Advocate Health Care signed an agreement in early February to enter into exclusive negotiations that could lead to the purchase of Dreyer Medical Clinic and Dreyer Health Plans of Aurora.

Acquiring Dreyer Health Plans would add 39,000-plus lives to BCBSI's managed care portfolio, said Dan Parker, vice president for public relations at Advocate Health Care. The purchase would also expand Advocate's ranks considerably, with the Dreyer Medical Clinic's 101 physicians at nine locations joining 3,500 doctors at 180 sites in the Chicago area.

"It's significant for Advocate because it would give us an entrance into the Fox Valley as well the far western suburbs," said Parker. "This is a vital area for us,

and [entering it] would enable us to establish a presence through a well-established, highly respected organization."

The Texas deal would create the second largest organization in the United States in terms of revenue, with a total of nearly \$6 billion, according to Arnold Widen, MD, vice president and corporate medical director of BCBSI. Current revenue for BCBSI is \$4.1 billion; revenue for BCBST is \$1.6 billion. The combined number of subscribers would be about 3.8 million.

Although complete details of the affiliation agreement have not been determined and a business plan for the boards of directors of both companies will not be unveiled until April, Dr. Widen said BCBSI President and CEO Raymond McCaskey will serve as the CEO and president of the combined company. Rogers Coleman, MD, CEO and president of BCBST, will become chairman of the board.

BCBSI'S DECISION to merge with Texas stemmed from its determination that the increasing growth and complexity in health care require such changes. "The rapid pace of change in the health care industry is creating new challenges and

opportunities on a nearly daily basis," McCaskey said at the news conference. "We believe that affiliating with a strong plan like Texas' [BCBS] is the best way to remain competitive in order to fulfill our mission, which is to have a positive impact on the quality, cost-effectiveness and accessibility of health care."

Dr. Widen said that the combined company would maintain a strong presence in each state and would continue responding to physicians' needs and concerns. "We're already physician-friendly, and we will continue to be so in the future." He pointed to an independent survey released last year by the Chicago branch of the Washington, D.C.-based Wyatt Co., in which Chicago metropolitan-area physicians rated BCBSI higher than other managed care providers.

"Physicians have had fewer problems with Blue Cross than other managed care entities, but they [BCBSI] could always be more physician-friendly," said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee.

Dr. Schneider said he believes the merger is based primarily on economic factors. "It gives them greater capital, and there will ultimately be one organization

making all the health care decisions."

A BCBSI spokesperson said that the geographic distance between the two states would have negligible impact on the combined company's business operations. "There are many different resources, including facsimiles and e-mail, that we can use to exchange information. What's more important is the philosophy and mission that we share and are committed to fulfill."

The spokesperson added that the merger was prompted by the tremendous growth opportunity for both plans, based on the large population of each state. As of January 1995, the population of both Illinois and Texas equaled one-eighth of the entire U.S. population, the spokesperson said, with 11.8 million residents in Illinois and 18.7 million people in Texas.

THE MERGER was generally viewed favorably by Standard and Poor's Register of Corporations, according to statements released by the rating service, because it would bring BCBSI's financial strength and expertise in managed care to the significantly larger market of Texas. "The most obvious benefit of the merger is the significant growth opportunity that it provides to the merged entity," the company noted. It did not, however, estimate the cost-savings expected from the combined company.

Before the merger is finalized, regulatory and board approval is required from the departments of insurance in both states and from each company. ■



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ISMIE Update

Watch for
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ISMIE increases policy limits for corporations and clinics

Change bolsters protection of these entities' assets. BY KATHLEEN FUREORE

Responding to physicians' changing liability needs, ISMIE has increased the amount of medical malpractice insurance coverage available to member corporations and clinics. During the past year and a half, ISMIE conducted studies that identified a higher-limit policy as one of several new products that would help policyholders adapt to the marketplace, said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors.

"Insuring individual physicians will always be the mainstay of our business," Dr. Jensen said. "As more and more physicians form large groups, however, the business of medicine changes. The asset base is becoming larger, so there is more at risk, more to lose. Corporate and clinic entities have a substantial capital investment in property, medical equipment, laboratory equipment and computers, and that investment needs to be protected from vicarious liability stemming from the acts of its physicians and employees."

To protect those assets, ISMIE now offers two high-coverage policies. One carries

limits of \$5 million per claim and \$5 million as an annual aggregate. The other has limits of \$5 million per claim and \$10 million as an annual aggregate, an ISMIE analyst said.

For a clinic with a \$5 million/\$10 million policy, ISMIE will pay up to \$5 million per claim per physician. The \$10 million aggregate limit is "the maximum ISMIE will pay on behalf of the clinic entity against claims made against all insureds in any one policy year," the analyst said. Previous limits available to clinics and corporations were \$500,000/\$1.5 million, \$1 million/\$3 million and \$2 million/\$4 million, he noted.

Many insurers make individual physicians buy the same high-limit policies in which their clinics invest. "They're paying for a lot of total aggregate coverage they don't need," the analyst said. But ISMIE doesn't require physicians to purchase the same high-coverage policies as their clinics. Each doctor will be able to carry \$1 million/\$3 million or \$2 million/\$4 million policies.

Because individual physi-

cians retain their own medical malpractice insurance, the higher limit coverage is used to pay a claim after a physician's per-claim limit has been exhausted. "It acts as a blanket or umbrella on top of other coverage to protect the entity, the physicians and other employees," Dr. Jensen said.

An Ob/Gyn sued in a "bad baby" case, for example, might have an individual policy that will pay \$1 million per claim. "But say you have a child with a life expectancy of 40 or 50 years," the analyst said. "That child will have tremendous health care and daily living expenses. And an Ob with \$1 million coverage is going to have a very difficult time settling the case. You don't want to be in a position to have to hand over the keys [to the clinic] someday. A \$5 million [per claim] corporate policy would provide the additional coverage needed to settle this kind of severe, high-damage case." ■

Illinois Medicine will continue reporting on new ISMIE products and services in upcoming issues.

ISMIE to work with Aon

Professional brokers from Aon are now authorized to represent ISMIE and sell ISMIE products, thanks to a contract the two companies recently signed. "Aon has a tremendous amount of resources and knowledge with respect to health care delivery," an ISMIE analyst said. "The company's market intelligence is invaluable to us. Aon knows what our competitors are up to and can help us get to clients we can't otherwise access."

ISMIE began working with brokers to enhance its offerings of products and services for policyholders. The move toward brokers was prompted by the escalation of managed care, which is casting nonphysicians like group practice administrators in insurance-buying roles.

"[This] is one way we can broaden the distribution of our products into those markets," said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. "[But] no policyholder will be forced to use a broker. It's freedom of choice. If a physician, group or clinic wants

to buy from us directly and maintain contact with ISMIE, they can."

"We can address a different market segment than ISMIE has pursued in the past — practice managers, for example," said Aon broker Bill Storie. "ISMIE has been terrific in dealing with individual physicians. But the business of medicine is now being controlled by the business community. That had to be addressed. And we have expertise in that area." Aon's resources will supplement ISMIE's and help ISMIE capitalize on the "tremendous growth opportunities" created through the evolution of health care, Storie said.

Aon is one of many carefully selected, highly qualified brokerages with which ISMIE plans to contract. The brokers will be required to help ISMIE retain its current business, help provide bids for new groups or opportunities they become aware of and inform ISMIE about competitors' offerings, the analyst explained. Working with brokers won't affect the cost of ISMIE coverage. ■

MALPRACTICE ROUNDUP

Court supports denial of coverage for autologous bone marrow transplant to treat brain cancer

Citing a policy exclusion for experimental treatment, a federal district court in North Carolina upheld an insurer's denial of coverage for an autologous bone marrow transplant to treat a rare brain cancer, according to the September 1995 issue of Medical-Legal Aspects of Cancer Litigation.

In the case, *Watts vs. Massachusetts Mutual Life Insurance Co.*, the plaintiff's treating oncologist at Duke University Medical Center recommended the treatment as the only chance of long-term survival for the patient.

The ruling cited evidence that the treatment was part of an investigational research study. The court found that if the insurer was required to pay for experimental treatment, it would suffer irreparable harm — not only because of the cost of the treatment, but because other policyholders would seek coverage for participation in experimental studies. In addition, the court said that because the treatment has not been proved effective for the patient's condition, it is unclear whether he would suffer harm if denied coverage. ■

California court dismisses informed consent case

A patient who sued a podiatric surgeon for negligence and lack of informed consent had his case dismissed by the appeals court in California.

The plaintiff, Harry Jambazian, consulted surgeon Joseph Borden about a callosus formation on his foot, reported the September 1995 issue of *Health Law Digest*. Following four office visits, the two discussed an ostectomy. Dr. Borden obtained Jambazian's written consent for the procedure, and the parties discussed the possibility of postoperative infection. The surgery was uneventful, but Jambazian developed and received treatment for a postoperative infection.

He then sued Dr. Borden for negligence and lack of consent. Jambazian argued that he has diabetes and would not have consented to surgery if he had known that being diabetic increased the risk of postoperative infection. He did not present expert testimony or proof of this condition, however, nor did it appear on his medical record.

The trial court entered summary judgment for the defendant, which Jambazian appealed. The appeals court upheld the judgment, noting that since the plaintiff failed to present proof he had diabetes, the physician had no duty to disclose or explain risks that were not medically indicated. ■

TRENDS

Applying the art

Laser technology as well as challenges

BY RICHARD SPERLING, MD

Practicing plastic surgery these days offers more ups and downs than a roller-coaster ride. On the one hand, plastic surgeons have the opportunity to refine laser surgery and expand its use. On the other hand, urging patients to be realistic about surgical goals is a perennial challenge. And looming around the bend may be the biggest challenge of all: convincing managed care plan administrators that plastic surgery can be more than cosmetic.

For them, the specialty connotes mainly elective procedures like face-lifts, rhinoplasty and liposuction. So plastic surgeons must often convince insurers, especially in managed care settings, that a procedure was performed to relieve symptoms, not just for aesthetic reasons.

"Unfortunately, most laypeople, insurers included, don't realize the extent of plastic surgery," said Richard Sperling, MD, a Skokie plastic surgeon. "This lack of knowledge of what we do and why it's done is a constant challenge for plastic surgeons."

One area that insurers may not fully understand is the difference between reconstructive surgery, which is performed on abnormal structures of the body, and cosmetic surgery, which reshapes normal structures of the body to improve a patient's appearance, Dr. Sperling said. As a result, patients run into coverage problems.

"Almost every day I have to explain to an insurer that a procedure I've performed on a patient isn't purely cosmetic," he explained. "For instance, an insurer initially rejected a claim for the removal of a nevus from a 3-year-old patient. Although the nevus was benign, it was removed because of its potential malignancy as a melanoma. [So] it was basically a reconstructive, not a cosmetic, surgery."

Procedures typically challenged by insurers range from abdominal surgery to alleviate back pain to eyelid surgery to correct drooping that obscures a patient's vision to nasal surgery that corrects deformities affecting a patient's breathing.

"Insurers hear the words 'plastic surgery,' and they see a red flag," said Mimi Cohen, MD, chief of plastic surgery at the University of Illinois at Chicago College of Medicine. "Insurers sometimes assume, a little too quickly, that a plastic surgical procedure is an unnecessary procedure. The physician then has to take the time to explain the nature of the problem. Once the reasons are given, insurers will most likely certify the surgery."

"There's a real problem, however, when it comes to pre-existing conditions," he continued. "Children with birth defects will need multiple reconstructive surgeries until their teen-age years. But if their parents switch insurance carriers, the new insurer may not reimburse them for the surgeries because they are classified as pre-existing. The California state legislature, in fact, has addressed this problem by passing a law

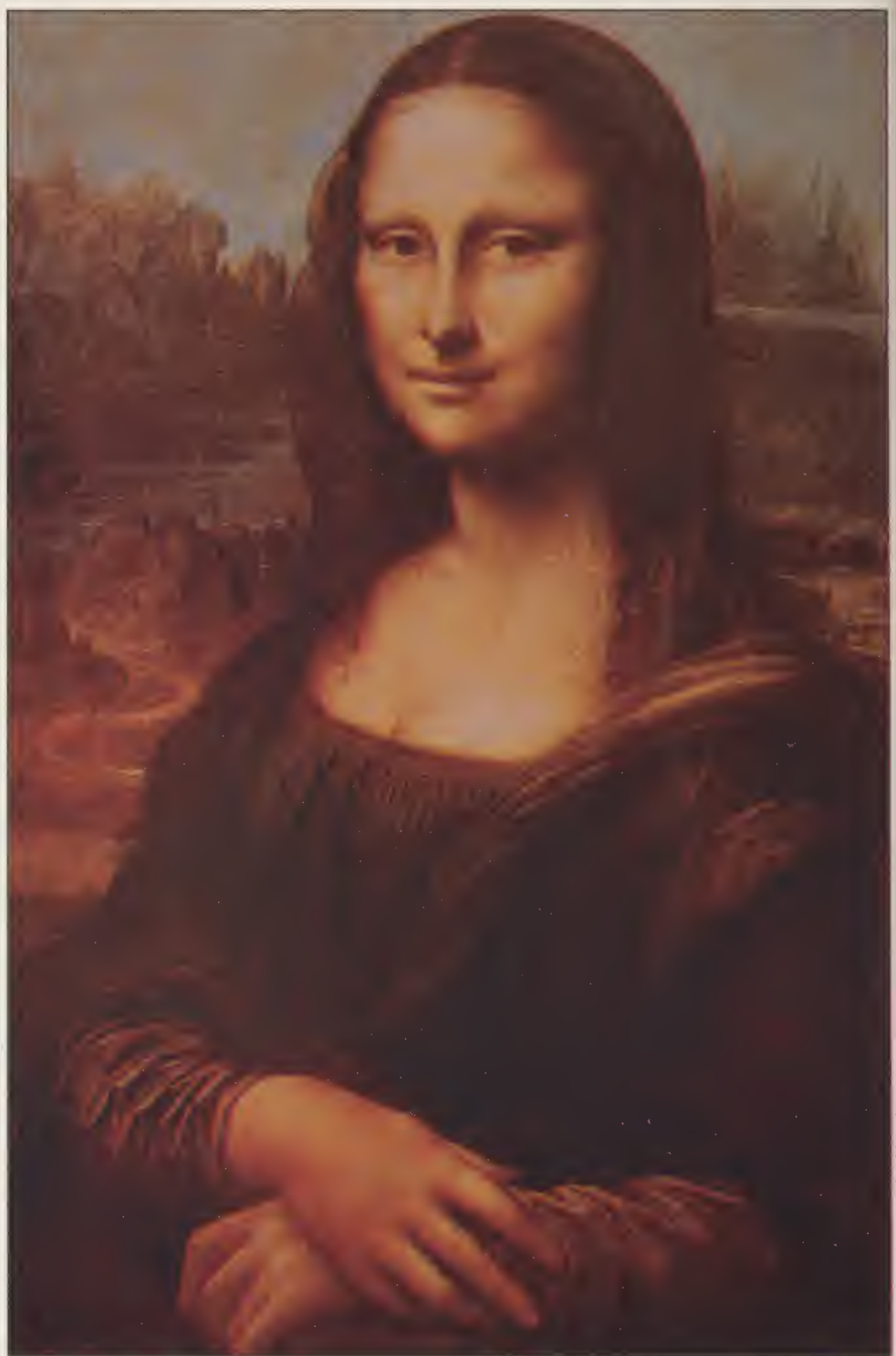


Image manipulation by Lyl Lauth

aimed specifically at children with birth defects needing such ongoing surgeries."

Reduction mammoplasty is another somewhat controversial procedure. "The shoulder grooving and neck and back pain that women experience are real health problems," said Elvin Zook, MD, chairman of

TRENDS

f plastic surgery

surers are transforming this specialty.

ZIET

the division of plastic surgery at the Southern Illinois University School of Medicine in Springfield. "This isn't just about reducing one's breast for the sake of appearance. And yet some insurers can't seem to comprehend the physical discomfort that separates these women from those who want a cosmetic change."

IN CASES in which patients have been in an accident or have experienced trauma, the determination that a procedure is reconstructive is usually easier, especially when it involves facial injuries or burns that can cause permanent disfigurement. But even in those cases, an issue arises: Who should do the procedure – the physician on duty or the plastic surgeon?

"If the emergency physician is uncomfortable about doing a certain procedure, then the plastic sur-

request of plastic surgeons most often, according to Dr. Cohen. Of course, even though these surgeries are commonplace, they're not necessarily simple or risk-free.

Advertising and media coverage may confuse the issue by emphasizing surgical procedures and benefits without providing specific details. As a result, patients may have only a vague understanding of a procedure and its possible complications, and they may have extremely high expectations of the outcome. So effective physician-patient communication becomes even more critical.

"Liposuction is a popular procedure because it doesn't leave unsightly scars and it appears to be risk-free," Dr. Cohen said. "But the plastic surgeon has to constantly remind his or her patients that cosmetic procedures can be complicated and can't be entered into without any thought. New technology, such as lasers, greatly assists the plastic surgeon, but this doesn't mean that all risks and possible complications have been removed."

With its reputation for eliminating imperfections and growths with minimal bleeding, bruising and scarring, laser technology has become one of the most popular innovations in plastic surgery today.

"Laser technology has in some respects dramatically changed many areas of plastic surgery," Dr. Sperling said. "But we need to keep in mind that lasers are still somewhat in the experimental stage. We have not seen the long-term effects of this technology. Much more research needs to be done."

Each laser is different because each laser is designed to do a different thing, Dr. Cohen said. Dr. Sperling explained that yellow pulsed dye lasers, which use a type of dye as their active medium, are used to treat birthmarks and leave minimal scarring. But many plastic surgeons now use pigment-blasting lasers to remove tattoos.

Laser equipment can cost \$120,000 or more, Dr. Cohen said. "Even though laser technology is expensive, its use still increases. It doesn't show signs of stopping."

"The medical benefits of lasers are evident," Dr. Sperling said. "The patient, though, needs to be sure the plastic surgeon is skilled in laser technology. The physician has to explain what the technology consists of and how many laser treatments will be needed to correct a problem."

AND THAT BRINGS physicians back to the importance of patient communication in dispelling any unrealistic expectations. During the initial consultation, surgeons typically ask patients to describe in their own words why they want a particular procedure. "If a patient wants a face-lift because he or she just went through a divorce, I would question the appropriateness of such a surgery given the patient's current psychological

(Continued on page 10)

Top five aesthetic procedures for the East North Central Region (Includes Illinois)

Liposuction	5,398
Eyelid surgery	4,406
Nose reshaping	3,353
Breast augmentation	3,150
Face-lift	2,243

Source: American Society of Plastic and Reconstructive Surgeons, 1994



geon would probably be called in," said Dr. Sperling. "But if you're talking about a tiny laceration, an insurance company will balk at paying for a plastic surgeon to perform such a simple procedure. The case has to warrant a plastic surgeon's care."

Dr. Zook, who is a past president of the American Society of Plastic and Reconstructive Surgeons, said a plastic surgeon is often called simply because the patient's insurance plan permits it. "Let's say it's 2 in the morning and I get a call from the emergency department to stitch up a 1-centimeter laceration. The patient may be demanding a plastic surgeon because his or her HMO allows it. The patient isn't paying extra, so why not?"

"The other side of this situation is that you may have a patient who really could benefit more by using the services of a plastic surgeon," Dr. Zook continued. "But if his or her insurance company doesn't interpret the procedure as a necessity, the patient ultimately loses out."

Away from the emergency department are such cosmetic surgeries as rhinoplasty, hair replacement and liposuction, which are the procedures patients

Applying the art

(Continued from page 9)

state," said Dr. Zook.

In addition to discussing general risks with patients, plastic surgeons are urged to cover additional risks specific to the patient or the procedure, such as hypertrophic or keloid scarring and asymmetry, according to the "Patient Consultation Resource Book," published by the ASPRS. The publication warns that non-operative procedures often require as much discussion as operative ones and recommends addressing drug therapy, including allergic reactions, cross-reactions and specific precautions.

"I always encourage the patient to get a second opinion from a board-certified plastic surgeon," said Dr. Sperling. "I want the patient to feel as confident as possible that he or she is doing the right thing and that his or her expectations are reasonable. The plastic surgeon has to make sure that the final decision for a plastic surgery rests with the patient — not with the spouse, friend or doctor.

"Lengthy consultations with the patient are necessary so the patient understands what the surgery will accomplish," Dr. Sperling continued. "If expectations are reasonable, you and the patient can both be satisfied with the results. In plastic surgery, you see the results of your work — and so does the patient."

Tattoo removal programs aim to help gang members



There's more to plastic surgery than face-lifts, rhinoplasty and liposuction. Two programs in Chicago and Elgin focus on helping gang members break away from their violent lifestyles through tattoo removal.

"They are desperate to get out of their gangs, but they have difficulty because of their tattoos, which are visible identifiers," said John May, MD, a senior staff physician at Cook County's Karmic Health Services and Cook County Hospital. He helped launch a tattoo removal program called Operation Fresh Start at the West Side Family Health Center in Chicago.

On Jan. 20, the first day the center was open for business, gang members poured into the complex. "We've been flooded with calls already this morning," Dr. May said. "It's hard to keep up with the volume of people here today, and there are more who want appointments for next week."

At the center that day, many gang members had tattoos in such visible places as on their faces, especially under their eyes, and on their hands. "Most gang members get their tattoos when they're 12 or 13 years old," Dr.

May said. "[Initially,] it gives them protection, and they feel it's an honor." But tattoos affect them in many negative ways, particularly later in life, he explained.

The program, held on Saturdays, costs participants \$25, but is free to those who submit a receipt for a handgun that has been turned into the Prevention Programs Division of the Chicago Police Department.

Dr. May patterned the program after one established in January 1995 at St. Joseph Hospital in Elgin. "We have treated approximately 400 tattoos on 200 patients, and have recorded more than 4,000 calls," said Patricia Affett, director of the Advanced Surgery and Laser Center at St. Joseph. In fact, the hospital received so many requests for the service, it was eventually forced to restrict the program to Elgin residents, she added.

Currently, Dr. May is the only physician in the Chicago program, but 15 other doctors are attending a training certification course from Continuum Biomedical Inc., the manufacturer of the laser equipment used to remove the tattoos.

The Elgin program is also seeking more physicians. It is currently managed by plastic surgeon Jay Rosenberg,

MD, who is assisted by dermatologist Vladimir Tkalecic, MD.

"I wanted to get more experience using the laser, and the closest place was [at St. Joseph Hospital], said Dr. Tkalecic, who makes a weekly 100-mile commute to help with the program. "Once I got started and heard all the stories about gang activity, I couldn't stop. The least I could do is to donate my time and skills."

"Removing tattoos takes anywhere from two to five treatments, and it is no more painful than when the tattoos were put on," Dr. May explained. "The treatments are all spaced about one month apart, and the number of treatments depends on the amount and type of ink used and the depth of the ink in the skin."

One client at the West Side Center, a girl named Elizabeth, had three tattoos removed so that she could begin work in an office the following week. "I don't ever want to do this again," she said during the procedure. Although she was obviously in pain, she said the removal procedure was less painful than her own previous attempt to remove the tattoo with a burning spoon. That method is fairly common among gang members, Dr. May said. "They're desperate to get them off, and they will do whatever it takes."

— Mary Nolan

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Illinois/nationwide: Need internist, family physician, pediatrician, dermatologist, Hem/Onc, Ob/Gyn, rheumatologist and more. CV to Stan Kent, SKA, P.O. Box 904, Tremont, IL 61568; (800) 831-5679.

Acute Care Inc., emergency medicine/locum tenens: Seeking quality physicians interested in emergency medicine or primary care locum tenens positions. Full time and regular part time. Numerous Illinois, Iowa and Nebraska locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact Acute Care Inc., P.O. Box 515, Ankeny, IA 50021; phone (800) 729-7813 or (515) 964-2772.

Internal medicine: Full-time or part-time BC/BE internist needed to join a busy practice in Chicago's northern suburbs. Please send replies to Box 2291, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Excellent opportunities for physicians in the Chicago and suburban areas. Single-specialty and multispecialty group practices, hospital-based and outpatient arrangements. Competitive compensation and benefit packages. For a confidential inquiry, contact Debbie Aber, (847) 541-9347; Physician Services, 1146 Parker Lane, Buffalo Grove, IL 60089; fax (847) 541-9336.

ENT practice established with excellent volume. Participates in private pay and HMO. Will send information upon request. Send replies to Box 2288, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Send ad copy with payment to Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602; (312) 782-1654, (800) 782-ISMS; fax (312) 782-2023. Illinois Medicine will be published every other Tuesday except the first Tuesday of January and July; ad deadlines are four weeks prior to the issue requested. Although the Illinois State Medical Society believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify advertisements at its discretion.

Busy dermatologist in southwest Chicago suburbs seeks BC/BE dermatologist for partnership. Fax CV to (708) 361-8083.

Robinson, Ill.: Crawford Memorial Hospital is seeking two primary care physicians to staff its emergency department. This is a career position with an annual remuneration in excess of \$110,000. Professional liability insurance procured on your behalf. Qualifications include a minimum of two years of emergency department experience and ACLS. For more information, contact Ed Kennedy, Coastal Physician Services, at (800) 326-2782, or fax your CV in confidence to (314) 291-5152.

Malpractice case evaluation: board-certified medical experts needed. All specialties. All locations. Defense and plaintiff cases. Excellent remuneration. Interested physicians, please contact and send CV to Barry Gustin, MD, FACEP, American Medical Forensic Specialist, 2991 Shattuck Ave., Suite 302, Berkeley, CA 94705. Phone (510) 549-1693, fax (510) 486-1255.

Southeast Chicago: obstetrician. Illinois license, DEA required. In-house position available evenings and weekends. Flexible scheduling. Malpractice insurance provided. Pleasant work environment. Please contact Diane Temple, (847) 654-0050, or fax your CV for confidential consideration to (847) 654-1203.

Benton, Ill.: Franklin County Hospital is seeking two physicians to staff its emergency department. This is a career position with an annual remuneration in excess of \$97,000. Professional liability insurance procured on your behalf. Qualifications include a minimum of two years of emergency department experience and ACLS. For more information, contact Ed Kennedy, Coastal Physician Services, at (800) 326-2782, or fax your CV in confidence to (314) 291-5152.

Physician, part time and/or full time: relaxed environment. Fax resume and salary history to (847) 272-0078.

Morrison, Ill.: Morrison Community Hospital is seeking a primary care physician to staff its rural health clinic in Prophetstown, Ill. Hours of operation are 9 a.m. to 5 p.m., Monday through Friday, with one on-call weekend per month. This is a career position with an annual remuneration of \$96,000. Professional liability insurance procured on your behalf. Qualifications: BP in primary care. For more information, contact Ed Kennedy, Coastal Physician Services, at (800) 326-2782, or fax your CV in confidence to (314) 291-5152.

Western Illinois – Outstanding opportunity for a board-certified or -prepared orthopedic surgeon to enter a market base of more than 40,000 as part of a multispecialty group. Canton, a charming community located in West Central Illinois, offers a full-service community hospital with state-of-the-art equipment, including MRI and CT scan. Canton and the surrounding area offer recreation, including golf, hunting and an assortment of water sports on several lakes, as well as a variety of cultural activities and excellent educational facilities. A very competitive financial arrangement is included with this opportunity. Contact Megan Black at (800) 862-9012 or fax your CV to (309) 685-2574.

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Established medical practice located in downtown Skokie, Ill., is in need of an internist or family physician for a full- or part-time affiliation with major hospitals. Please contact Paula at (847) 329-0470.

Public health medical residency: Practicum has core of infectious disease, environmental health, maternal and child health, epidemiology, and administration; electives in many other areas available. Practicum can be tailored to physician's needs and interests. MPH a prerequisite; may be earned in high-quality affiliated program. Write to B. Francis, MD, Illinois Department of Public Health, 525 W. Jefferson St., Springfield, IL 62761; or phone (217) 785-7165, TTY (hearing impaired use only), (800) 547-0466. EOE/AA/ADA employer.

Pediatrician needed part time. Bilingual, English/Spanish preferred. Clinic setting. Call (312) 522-5200, Mrs. Gomez.

General internal medicine – Long Grove: Immediate opening with well-established private practice. Part-time, three office days per week, 30-percent weeknight call, 25-percent weekend call. \$65,000/year. Fax resume to (847) 634-2140.

Internist – downtown Chicago: Three BC internists with offices located on Michigan Avenue seeking fourth BE/BC internist. Modern clinic facility and affiliation with a licensed 500-bed teaching hospital. Excellent guaranteed income plus full benefits. Contact Charles Matenaer at (800) 611-2777.

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Chicago – western suburb: excellent family practice opportunities in a highly desirable suburban community. Single-specialty, private practice and urgent care positions available. Competitive compensation and benefit package with bonus potential. Board certified or eligible. Respond to Donna J. Schalke, Physician Service Assistant, Edward Hospital, 801 S. Washington, Naperville, IL 60540; phone (708) 527-3659; fax (708) 527-3702.

Internist or family physician, BC/BE: multispecialty group located in western suburbs. Full or part time. Excellent environment. Please send replies to Box 2290, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Locum pediatrician needed: northwest suburbs. Daytime only for office practice. March 25-30 and May 6-11. Call (847) 742-9711 or fax (847) 742-9743.

Illinois: Immediate opportunity for a board-certified or -prepared family physician to join three others in multispecialty group of nine physicians in Ottawa, Ill. The Ottawa Medical Center, P.C., is a state-of-the-art complex affiliated with 155-bed Community Hospital of Ottawa. Practice includes an excellent call schedule and competitive financial package. Ottawa, located about 90 minutes from downtown Chicago, is surrounded by four beautiful public parks and offers one of the finest educational systems in the state. For more information, contact Steve Baker at (800) 430-6587 or fax CV to (309) 685-2574.

Medical director: Alivio Medical Center is a not-for-profit community health center that serves a predominantly Mexican community and is located in the heart of Chicago, four miles from downtown. This position provides clinical, administrative and teaching leadership; requires managed care experience or compatible practice style and commitment to being a medical director; and is an integral part of a collaborative management team. Please send letters of interest, resume and three current letters of reference to Carmen Velasquez, Executive Director, Alivio Medical Center, 2355 S. Western Ave., Chicago, IL 60608.

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South Suburban Chicago

Various opportunities exist for Family Practice, Pediatric and Internal Medicine physicians to practice medicine the way they want to at South Suburban Hospital, a 220-bed not-for-profit, acute-care facility. Be part of the growing suburbs of Chicago's Southland, located less than one hour from Chicago's Loop.

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**April Chattinger, Director
Practice Development
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17800 So. Kedzie Avenue
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(708) 799-8000, ext. 3580**

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Pediatrician/family practice: This position will provide the opportunity to care for infants and children, be part of a physician team, be a member of a comprehensive primary care community health center. Having managed care experience or compatible practice style is an important requirement as we enter the managed care environment. Must be bilingual – Spanish. Please send letters of interest, resume and three current letters of reference to Carmen Velasquez, Executive Director, Alivio Medical Center, 2355 S. Western Ave., Chicago, IL 60608.

Family practice – Terrific opportunity available for the board-certified or -eligible family physician in the charming community of Glasford, Ill. The practice is part of the Order of Saint Francis (OSF) Healthcare System's progressive, integrated Primary Care Network and offers an attractive salary and comprehensive benefits package. Solo practice is managed by OSF Practice Management, permitting focus on patients, not paperwork. Glasford, located within an easy commute to Peoria, offers a wonderful family atmosphere with great schools and beautiful homes. For more information, contact Dawn Hamman, 4541 N. Prospect, Peoria, IL 61614. Phone (800) 438-3740, or fax your CV to (309) 685-2574.

Situations Wanted

Board-certified, experienced radiologist seeks hospital or clinic position. Experienced in interventional radiology, MR and all types of imaging modalities. Please send replies to Box 2284, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

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Experienced, board-certified gynecologist seeks hospital association, primary care association and/or to take over an active practice in gynecology or family practice. Please send replies to Box 2273, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Administrative practice manager/medical transcriptionist available for part-time position, could turn into full-time. Excellent references. Please send replies to Box 2289, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Board-certified osteopathic family physician seeks full-time position (MD or DO) affiliated with teaching hospital in Chicagoland area. Extensive managed care experience. Available summer 1996. Please send replies to Box 2286, % Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Board-certified internist seeks part-time position in Chicago or northern suburbs. Please call (312) 743-1608.

Canadian family physician, Canadian certified (CCFP), U.S. BE, NMBE certified, seeking diverse challenging practice in Chicago area beginning summer 1996. Evenings, (416) 696-9265.

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Oak Brook Terrace medical office to share/sublease. Fully furnished, X-ray diagnostic lab, treadmill, Holter, etc. Freestanding building, high visibility, parking (Summit Avenue). Call (708) 629-6700.

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East Dundee medical office to share/sublease, fully furnished, new build-out in free-standing building, easy access from I-90, near major area hospitals, spacious parking. Call (708) 622-1212.

For sale: used Ob/Gyn office equipment/furnishings. Inquiries: (618) 283-1622 or VOGA, 929 Walton Drive, Vandalia, IL 62471.

Jamaica villa in Silver Sands private international beach-club community halfway between Montego Bay and Ocho Rios. Our luxury villa has a large swimming pool, four bed/bath suites. Daily cook and maid furnished. Ideal for families or friends vacationing together. Tranquility assured. \$2,500-\$3,300, winter season; \$1,800-\$2,200 per week from 4/15. (800) 260-1120.

Commercial offices: Lovely professional two-story building with frontage on Route 68 just north of Route 72 in established East Dundee. There are seven office suites that are fully rented with long-term leases. Good rate-of-return investment. 7,200 square feet of quality space. Newer roof, completely blacktopped for 50 cars. Backup package available. \$625,000. Call Judi Falbisaner at (847) 428-LADY.

Naperville – Outstanding medical space for lease: 1,110 square feet in an 18,000-square-foot medical center. Three examination rooms, private office, reception area, administrative area, waiting room and private restroom. Excellent location – immediately off Ogden Avenue. Contact Bill Waliewski, McWilliams & Associates Inc., at (708) 357-9044.

For sale: Calyx MDX system software program with all latest updates included. Complete billing and insurance system – \$3,000, firm. Please send responses to P.O. Box 483, Edwardsville, IL 62025.

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Fox Valley medical office for sale in fast-growing Kane County (west of Chicago). Services Geneva, Batavia and St. Charles, population of about 75,000, 10 minutes from I-88, also near Elgin and Aurora. Also available, X-ray, furniture and personnel from existing surgical and family practices. Call Joan, (708) 232-1500.

Medical clinic facility: immediately available, 5930 N. Broadway, Chicago. Fifteen exam rooms and offices, waiting room; recently remodeled, 6,500 square feet, suitable for medical, dental, optical and pharmacy. High-density population, adjacent parking, partially equipped, rent negotiable. Call (312) 283-2700.

Two custom-made 30-inch-by-20-inch white formica hand exam tables on stainless pedestal, two adjustable rolling stools, two twin-arm adjustable white floor lamps, all \$1,000. (312) 787-1379.

Three new exam tables for sale. Will take best offer. Please contact Stephen if interested, (800) 259-6269.

Miscellaneous

Birchbark canoe building course: 16 days, summer 1996, on Lake Superior (Wisconsin). Information: David Gidmark, Dept. 01, Box 26, Maniwaki, Quebec J9E 3B3.

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Fifth Annual Neurology for Primary Care Providers conference: Friday and Saturday, May 17-18. Landmark Inn Resort and Conference Center, Egg Harbor, Wis. Contact Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave., Marshfield, WI 54449; (800) 541-2895.

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Legislation signed

(Continued from page 3)

Controlled Substances Act

Changes to the Illinois Controlled Substances Act were approved by the General Assembly during the 1995 spring legislative session and were signed by the governor on July 21. Those changes, which became effective Oct. 1, exempt certain providers licensed by the Illinois Department of Public Health from the state's triplicate prescription program. Exempted providers include skilled nursing facilities, intermediate care facilities and long-term care facilities for residents under 22 years old. Other exemptions include home infusion services provided by pharmacists to patients in private residences, long-term care facilities and hospice settings.

"These changes should decrease the regulatory burden on medical providers and ease their paperwork," said Sue Gorman, a regulatory supervisor for the Triplicate Prescription Control Program of the Illinois Department of Alcoholism and Substance Abuse.

With the changes, physicians need only issue a written prescription, whereas previously they had to apply for forms, pay a \$10 processing fee and wait seven days before receiving them, Gorman said. She explained that with the new law, physicians may send a written facsimile prescription for any Schedule II controlled substance directly to the dispensing pharmacy without obtaining triplicate forms. ■

OBITUARIES

*Indicates member of ISMS Fifty Year Club

*Fox

Ben Fox, MD, a general surgeon from Marion, died April 12, 1995, at the age of 92. Dr. Fox was a 1925 graduate of the Washington University School of Medicine, St. Louis.

Hillstrom

William J. Hillstrom, MD, a family physician from Crystal Lake, died March 31, 1995, at the age of 65. Dr. Hillstrom was a 1954 graduate of the University of Illinois College of Medicine, Chicago.

*Hootnick

Harry L. Hootnick, MD, an internist from Oak Park, died May 18, 1995, at the age of 84. Dr. Hootnick was a 1942 graduate of the Chicago Medical School.

*Hussey

Lemuel B. Hussey, MD, a general practitioner from Savanna, died May 29, 1995, at the age of 89. Dr. Hussey was a 1931 graduate of the Northwestern University Medical School.

Koinis

Kostas E. Koinis, MD, a pediatrician from Chicago, died May 26, 1995, at the age of 70. Dr. Koinis was a 1949 graduate of the Faculty of Medicine, Aristotelian National University of Athens, Athens, Greece.

*Love

Loren L. Love, MD, a general practitioner from Christopher, died Jan. 13, 1995, at the age of 88. Dr. Love was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

McNulty

Philip P. McNulty, MD, a general practitioner from River Forest, died May 17, 1995, at the age of 72. Dr. McNulty was a 1946 graduate of the Loyola University Stritch School of Medicine, Maywood.

*Moser

H. R. Moser, MD, a general practitioner from Bonita Springs, Fla. (formerly of Hurley, Wis.), died May 24, 1995, at the age of 85. Dr. Moser was a 1939 graduate of the Chicago Medical School.

*Orndorff

John R. Orndorff, MD, a general surgeon from LaGrange Park, died May 15, 1995, at the age of 87. Dr. Orndorff was a 1935 graduate of the Northwestern University Medical School.

*Schroder

Harold M. Schroder, MD, a general practitioner from Pontiac, died April 8, 1995, at the age of 84. Dr. Schroder was a 1935 graduate of the Loyola University Stritch School of Medicine, Maywood.

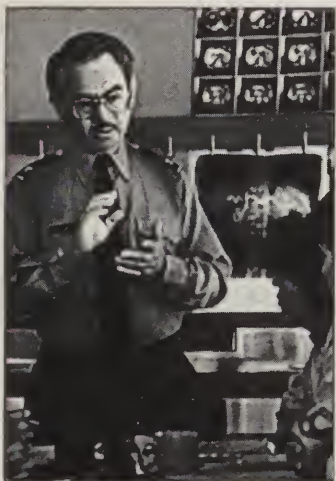
*Swigert

Verne W. Swigert, MD, an internist from Evanston, died July 2, 1995, at the age of 87. Dr. Swigert was a 1936 graduate of the Northwestern University Medical School.

*Udesky

Isadore C. Udesky, MD, an Ob/Gyn from Los Angeles (formerly of Flossmoor), died May 29, 1995, at the age of 86. Dr. Udesky was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

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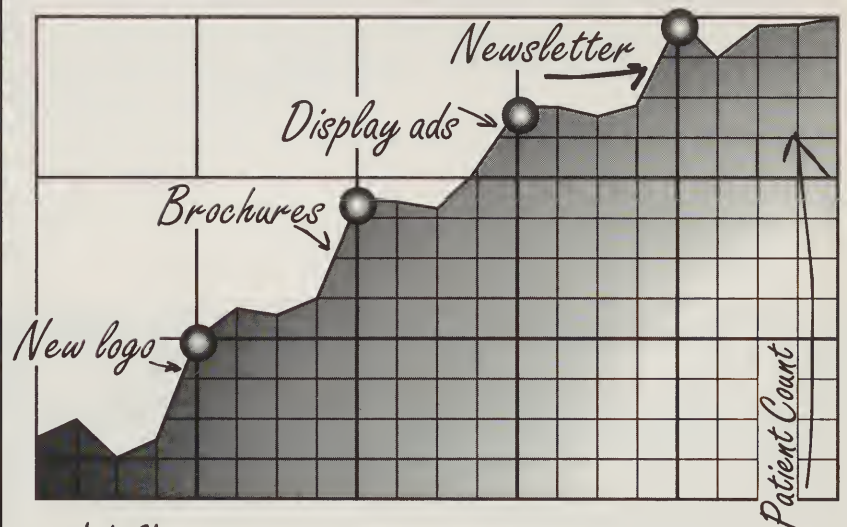
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ISMS announces

(Continued from page 1)

and make sure they have all the information necessary to make their choice."

"I can't think of a more important public policy right now than that of patient rights with respect to managed care," said Rep. Tom Cross (R-Yorkville), a lead sponsor of the bill.

"This General Assembly has the opportunity now to take a leadership role in the issue of patient rights in managed care," Cross added.

"Is there too much manage[ment] and not enough care?" asked lead sponsor Sen. Dan Cronin (R-Elmhurst). "We will be carefully examining this question."

Other sponsors include Sens. Doris Karpel (R-Roselle), Penny Severns (D-Decatur), Denny Jacobs (D-Moline), James Clayborne (D-East St. Louis) and Arthur Berman (D-Chicago); and Reps. Kay Wojcik (R-Schaumburg), Judy Erwin (D-Chicago), Jeff Schoenberg (D-Wilmette) and John Turner (R-Lincoln).

Co-sponsoring the bill are Reps. Anne

Zickus (R-Palos Hills), Angelo Saviano (R-River Grove), Roger McAuliffe (R-Chicago), Rosemary Mulligan (R-Des Plaines), William Black (R-Danville), Patricia Reid Lindner (R-Sugar Grove), David Wirsing (R-DeKalb), Gwenn Klingler (R-Springfield), Edgar Lopez (D-Chicago), Kurt Granberg (D-Carlyle), Sara Feigenholtz (D-Chicago), Suzanne Deuchler (R-Aurora), Douglas Hoeft (R-Elgin), Brent Hassert (R-Lemont), Julie Curry (D-Mt. Zion), Jack Kubik (R-Berwyn), Larry Wennlund (R-New Lenox), Stephen Alan Spangler (R-Morris), Jim Durkin (R-Westchester), Maureen Murphy (R-Oak Lawn), Terry Deering (D-Nashville), Louis Lang (D-Skokie), Mary Flowers (D-Chicago) and Judy Biggert (R-Westmont).

More than 25 state legislatures have already considered similar proposals, according to Cronin. But Larry Barry, an insurance industry lobbyist who was quoted by some media in the next day's coverage of the news conference, said that studies conducted in those states indicate that health care costs increased significantly.

"We are arguing for the quality of

care to remain in the health care system, [because] if you truly maintain quality, you can be cost-effective but you can't squeeze out as many dollars as some insurance companies want," Dr. Hoffmann told Illinois Medicine. He cited a 1995 study conducted by an independent health care consultant group in Rockford. It showed an increase in costs when newborn babies were discharged after one day, because they usually developed problems that required a return to the hospital. "Patients and physicians grapple with this on a daily basis," he said. "We think it's a symptom of a larger problem, and that's the cost-driven interference in the physician-patient relationship."

Some cost-driven systems generate high revenues but use significant portions of those revenues to pay their executives or for overhead instead of returning them to medical care, according to an article published in the Oct. 23, 1995, issue of Medical Economics. The story cited the second largest HMO in the Sacramento, Calif., area, which the California Medical Association ranked as the state's second-worst health plan in terms of the portion of revenues it spends on medical care. The HMO's so-called medical-loss ratio was 74.7 percent, meaning that 74.7 percent of its revenues were returned to health care, according to the CMA. Yet the HMO gave its chief executive officer a \$13.7 million compensation package two years ago.

In follow-up interviews with Illinois Medicine, some of the bill's sponsors said they believe a strong physician-patient relationship is essential to a quality health care system. Severns, who was diagnosed with breast cancer two years ago and is currently undergoing chemotherapy, said she selected her health care plan based solely on which one would allow her to continue with her treating physician. "I want to make sure that my physician and I are making the decisions regarding my health and not insurance companies," Severns said she applauds ISMS for "taking the initiative to advance a plan that is geared toward patient rights and that guarantees patients a right, in consultation with their physician, to make decisions in the

best interests of their health."

"Once the bill gets debated, legislators will reveal their own stories," Cross said. "This will help us gain momentum as the bill works its way through the General Assembly."

HCFA implements

(Continued from page 1)

remove cataracts, for example. They are mutually exclusive of one another when they're done on the same eye [of the same patient]," Cooper said.

While HCFA does not anticipate that the revised coding policy will have a significant financial effect on physicians, doctors should be aware of the potential for problems, Cooper said. "If physicians have been coding correctly, this shouldn't touch them." Chances are, however, that most physicians have other people doing their billing, and those individuals may not understand the descriptions of the procedures, she explained. HCFA's intent is not to punish physicians, but to "standardize the interpretation of the codes and get more uniformity in reporting," Cooper added.

But the medical community is concerned that the coding initiative was implemented too quickly and without an effort to educate physicians, said John Schneider, MD, chairman of ISMS' Third Party Payment Committee. "The concern from my standpoint is that maybe what physicians are doing is exactly what is outlined. But there is uncertainty, and that is compounded by the fact that doctors have to pay a hunk of money to find out [if what they've been doing is correct]." The coding policy is available in paperback for \$189 and on disk for \$90. It is included in the 2,200-page National Correct Coding Policy Manual for Part B Medicare Carriers.

"And there's been no education on the part of the carrier," Dr. Schneider continued. "The implication was that [before implementation], there was going to be an education process [for physicians], but there only was what was in the Medicare Part B Bulletin."

The changes have been "publicized to all physicians in the state" through the bulletin and in the Blue Sheet, said Douglas Busby, MD, Medicare medical director for Health Care Service Corp., the Medicare intermediary and carrier for Illinois. He said that he and members of the HCSC carrier education team are addressing the topic at various forums. "We also encourage providers to give the carrier a call if they have questions."

Dr. Busby said there is a difference between inappropriate coding – doctors making unintentional coding errors – and deliberately coding to increase reimbursement inappropriately. While the issue of punitive actions has not been addressed, deliberate miscoding "would be investigated," he said.

HCFA selected the Indiana Medicare carrier AdminaStar Federal to develop the new national system of coding edits in August 1994. The carrier distributed a draft of the revised policy to physician specialty societies through the AMA and with Medicare Carrier Medical Directors for comment that December. Based on comments received, AdminaStar removed 5,711 code combinations and will continue to evaluate another 1,000 code combinations, Cooper said.

Bill establishes patient rights

The Managed Care Patient Rights Act provides patients with the following basic rights:

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- Freedom of choice of physician to coordinate health care,
- Confidence that the patient's health care providers are free to advocate on his or her behalf for medically necessary health care,
- Clear and understandable information about the terms and conditions of managed care plans and health insurance,
- Information on managed care plan performance in providing quality care,
- Mandatory minimum maternity benefits,

- Privacy and confidentiality in the use of health care services,
- Knowledge of the identity of the patient's participating providers,
- A reasonable explanation of the plan for the patient's care,
- A reasonable explanation of bills for services,
- Freedom to purchase necessary health care services,
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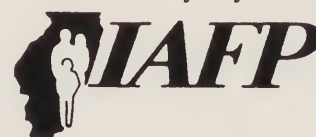
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Doctors dive into the Internet

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MARCH 15 1996

Group opposes name reporting in HIV cases

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Judge upholds one tort reform provision, strikes down two others

DECISION: Cook County judge says disclosure of medical experts' identity is constitutional but protection from vicarious liability and changes to the Petrillo doctrine are not. BY KATHLEEN FURORE

[CHICAGO] In one of three rulings on challenges to Illinois' 1995 tort reform law, Cook County Judge Kenneth Gillis on Feb. 27 upheld as constitutional a provision that tightens the state's affidavit of merit requirement. That provision requires plaintiffs to provide the name and address of the physician or other health care professional who reviews a case and certifies its merit, according to ISMS General Counsel Saul Morse.

"Plaintiffs argue that the disclosure of the name and address of the reviewing health care professional 'runs afoul' of [an] Illinois Supreme Court's decision and violates three provisions of the Illinois Constitution," Gillis wrote. "I disagree with the plaintiffs' positions." He said that a "close reading" of the Supreme Court decision and another related case "reveals nothing that hinges around the nondisclosure of the medical health care professional's identity, or anything which would ban disclosure. A significant number of Appellate Courts also have found [the provision] constitutional, against a variety of challenges."

"Are we happy with this ruling? Absolutely!" said ISMS President Raymond Hoffmann, MD. "You always want to make sure [the reviewing party] is truly a licensed physician with appropriate credentials. And if there's no name, there's no way of

checking." Requiring disclosure before proceeding with a lawsuit will also help stabilize the costs of litigation, he added.

In addition, that disclosure makes defending medical malpractice suits easier and is likely to decrease the number of cases filed against Illinois doctors, according to Chicago-area defense attorneys. If the reviewing physician is not considered knowledgeable, "we can then challenge the accuracy of the doctor's report and whether there is a reasonable meritorious cause for filing," said Fred Grossman, an attorney with Clausen, Miller, Gorman, Cafrey & Witous in Chicago, shortly after the tort reform legislation passed.

Gillis found two other provisions of the tort reform law unconstitutional, however. One of those provisions, which modifies the Petrillo doctrine, says patients who file medical malpractice suits must authorize the release of their medical records to the defendant within 28 days. If they fail to do so, defendants can seek a court order to obtain the records or have the case dismissed.

Mandating that plaintiffs turn over confidential medical records is "the absolute relinquishing of a constitutional right to privacy," Gillis wrote. "No area is more private than a person's medical background."

The Petrillo doctrine, estab-

lished in 1986, precludes physicians and defense attorneys from communicating without the plaintiff's express consent and outside the presence of the plaintiff's attorney. The modification Gillis struck down would have "sped up the litigation process and made it less costly," Morse said.

"Petrillo unfairly handcuffs defendant physicians so they're unable to obtain information without a formal deposition process every step of the way," Dr. Hoffmann said. "We think that when people file suit, they're asking for judgment on their personal health, and it's only fair that both sides have access to the information."

In contrast to Gillis' decision
(Continued on page 11)

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ISMS PSO workshop urges physician leadership



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Ron Ackerman

ISMS PRESIDENT Raymond Hoffmann, MD, answers questions about the Managed Care Patient Rights Act during Feb. 6 live satellite interviews with television stations across the state. The format linked Dr. Hoffmann in Springfield to stations in Rockford, Peoria, Quincy, Rock Island, Champaign and Evansville, Ind.

Legislators voice support for MCPRA

ADVOCACY: Bipartisan lawmakers speak out on the need to maintain the physician-patient relationship.

BY MINDY S. KOLOF

[SPRINGFIELD] Patients need full disclosure about their care and treatment options, an end to drive-through deliveries and a health care delivery system that centers on them, according to some legislative supporters of the Managed Care Patient Rights Act. They told Illinois Medicine that the bill is vital to assuring quality health care in Illinois.

MCPRA has evoked bipartisan support, even from proponents of managed care like Rep. Judy Erwin (D-Chicago), one of the bill's sponsors. She believes "in the real promise of managed care," and her voting record shows her support, she said.

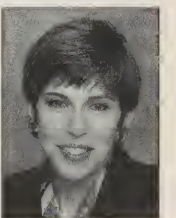
"In its purest sense, [managed care should provide] a holistic approach to health care," Erwin said. "A doctor used to be able to say, 'I know the Smith family; the father had a heart attack; the son is predisposed to cardiovascular problems.' He knew, because he'd been treating them for years."

That was Erwin's idea of managed care, but the reality has proved to be different, she said. "It's about managing costs, and not about quality care for patients."

The bill is important because it will return health care delivery to a patient-centered system in which health care decisions are between physician and patient, not insurance executives, Erwin added.

Overall, MCPRA aims to enable patients to receive quality care, to be informed about that care and the bill for it, to learn about any changes in coverage in a timely way, to be assured of privacy and confidentiality, and to buy extra services on their own.

"The situation has gotten out of hand when it comes to
(Continued on page 11)



Erwin



Jon McGinty

INTERNIST Marc Schlesinger, MD, explains how the Dreyer Medical Clinic in Aurora formed its HMO at an ISMS Physician Services Organization workshop in Rockford on Feb. 7. The workshop was one in a series of programs focusing on the need for physician leadership in managed care and the Society's proposed PSO.

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Group opposes name reporting in HIV cases

PUBLIC HEALTH: The AIDS Foundation of Chicago solicits physician opposition. BY KATHLEEN FURORE

[CHICAGO] Some Illinois physicians recently received a document soliciting their opposition to an ISMS-sponsored Illinois Department of Public Health proposal that would require doctors to report the names of their HIV-infected patients to IDPH. The AIDS Foundation of Chicago began sending its letter, or "statement of opposition to mandatory names reporting," to physicians in late January, according to David Munar, a policy associate with the AIDS Foundation.

"We want to show that many physicians who work with us and care for people with HIV and AIDS think this is poor public health policy and that they're concerned their [patients] will not continue to seek HIV testing at their offices," Munar said. "Our belief is that

even though many people seek testing from confidential or anonymous testing sites, there is a large group wanting more confidentiality and privacy that seek testing from their individual physicians."

ISMS supports the IDPH proposal to add names of HIV-positive individuals to the state registry of demographic data, said ISMS President Raymond Hoffmann, MD. He discouraged physicians from signing the AIDS Foundation's statement: "While we support activities to guarantee the continuation of privacy, we also recognize the need for collection of statistical data and enforcement activities for the public good. HIV reporting by name will allow for contact tracing and early detection of HIV disease in

order to improve the long-term quality of life of infected individuals. Our patients deserve timely diagnosis and follow-up services."

Dr. Hoffmann noted that more than 30 states already require such reporting. He cited a Maryland survey on nationwide HIV reporting that showed "that there have been no problems at any time with patient confidentiality at either the state or local level." ISMS also supports specified anonymous testing sites for individuals "not inclined to seek testing" in physicians' offices, he added. The Society's official position states that the reporting of HIV-infected individuals to the public health authority should be mandated and that exposed sexual partners should be notified about the infect-

ed individual's HIV status. "Our physicians think HIV is a public health problem and should be reported like many other diseases. There is name tracing of TB and syphilis, for example," he said.

IDPH Director John Lumpkin, MD, concurred that studies of other states' HIV registries do not support the fear that people will stop being tested. "In the worst cases, some states did experience a drop in testing during the first year. But after that, the numbers went back up and sometimes even exceeded what they were before." And when testing in physicians' offices declined, the number of tests at anonymous sites usually increased, he said. "So the total number of tests performed at the combination of the two sites was higher than before." If the Illinois registry is changed to include the names of HIV-positive individuals, the names will remain confidential, and there will continue to be anonymous testing sites, Dr. Lumpkin noted. ■

IDPH revises lead screening guidelines

CHANGES: Department will recommend change from universal to targeted blood lead screening in response to revised law.

BY KATHLEEN FURORE

[SPRINGFIELD] Illinois pediatricians and family physicians will soon receive new guidelines on lead screening from the Illinois Department of Public Health, according to Stephen Saunders, MD, chief of IDPH's Division of Family

Health. IDPH changed the Guidelines for the Detection and Management of Lead Poisoning for Physicians and Health Care Providers in response to revisions in the state's Lead Poisoning and Prevention Statute, which was

signed into law last fall. The revised statute requires targeted rather than universal blood lead screening of children 6 months through 6 years of age. It also instructs IDPH to identify high-risk communities in which universal blood lead screening will be recommended and to develop a risk assessment questionnaire for low-risk communities, Dr. Saunders said.

"It is anticipated that this change from universal screening to a targeted high-risk approach will enable physicians and health clinics to focus their blood lead screening efforts [on] those children at greatest risk," Dr. Saunders continued. "This approach should not only be more effective at identifying all Illinois children with lead poisoning but prove more efficient and cost-effective."

Because rules implementing the revised statute have not been published in the Illinois Register, the guidelines "do not have the force of law [but are] recommendations at this point," Dr. Saunders said. "They are based on the department's view and on the input of physicians. I think most physicians will appreciate them."

IDPH CONVENED the Medical Advisory Committee last fall to help the department identify high- and low-risk areas and develop the new guidelines. Key criteria used to determine risk were the age of housing – especially structures built before 1960 – and the number of children in families with incomes below the poverty level, Dr. Saunders said.

As part of routine well child care, all children from 6 months through 6 years should receive a risk assessment to determine potential environmental exposure to lead. One-year-olds are the highest-priority age group for assessment and screening, since the identification of lead exposure then offers the greatest potential for preventing further exposure, the guidelines say. They also recommend universal blood lead screening at ages 1 and 2 for children who live in high-risk communities. Children in low-risk areas should be assessed using IDPH's risk assessment questionnaire, which asks such questions as whether the child lives in or regularly visits a home or building built before 1960 and if a child lives with someone whose occupation or hobby exposes him or her to lead. When the answer to at least one

Change in lead reporting requirements for labs

Revisions to the Illinois Lead Poisoning and Prevention Statute signed into law last fall require directors of clinical labs to report the results of all blood lead analyses performed at their facilities to the Illinois Department of Public Health within 48 hours, according to Stephen Saunders, MD, chief of IDPH's Division of Family Health. Previously they were responsible for reporting results within 48 hours only if analyses showed a blood lead level of 10 or more mcg/dL, Dr. Saunders said.

"To determine the proportion of kids with elevated levels we need to know the number of all tests performed," Dr. Saunders explained. "But [the change] affects only labs, not physicians unless they're running labs."

ISMS supported the legislation that imposed the reporting requirement, said an ISMS analyst. But the Society will address the concerns expressed by some labs when it analyzes the proposed rules implementing the legislation. Those rules will soon be published in the Illinois Register. ■

— Kathleen Furore

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of the form's seven questions is positive, a blood lead test is required, the guidelines say.

In addition, the guidelines give physicians up-to-date information about the medical management of lead poisoning and offer treatment recommendations for asymptomatic and symptomatic children with blood lead levels ranging from 10 to 70 or more mcg/dL.

"By following the recommendations, we can further improve Illinois' excellent progress in identifying and treating lead-poisoned children and modifying their living environment to reduce further exposure to lead," Dr. Saunders said. "Our goal must be the prevention of this silent epidemic of lead poisoning." ■

ISMS PSO workshop urges physician leadership

MANAGED CARE: Patient advocacy depends on physician direction, speakers say. BY MARY NOLAN

[COLLINSVILLE] At a Feb. 15 ISMS workshop in Collinsville, Robert F. Hamilton, MD, challenged physicians to develop and lead managed care entities. The Collinsville workshop was one of seven statewide programs encouraging physicians to assume leadership roles and explaining how the Society's proposed Physician Services Organization would support them by providing consulting, practice management and information systems services.

Physician leadership is not an oxymoron but a necessity, said Dr. Hamilton, an ISMS Sixth District trustee from Alton. "We, as physicians, feel so strongly opposed to third-party-payer intrusion into our management of our patients that we have [previously] participated in such programs with great reluctance." But today, more doctors are participating in managed care programs – sometimes at the request of their patients – and "have found the deck stacked against us," he explained. "All of us are looking for alternatives to the arbitrary and capricious requirements of most insurance-driven and hospital-driven managed care."

That theme was also emphasized by ISMS Past President Arthur Traugott, MD, of Champaign. "Our long-standing relationships with patients and their families are threatened each time the patients' employers reconsider their health benefits programs."

Despite such physician concerns, managed care is establishing a foothold in Illinois, with HMOs in the state claiming more than 2 million members, "surprisingly high for the Midwest," Dr. Traugott said. "Market analysts consider our medical delivery system in Illinois to be in transition to a highly managed marketplace. We're right in the middle of fee for service and total managed care."

Characteristic of this stage of transition is confusion as old patterns break down, he continued. "Large delivery systems are purchasing physicians' practices, and health plans are consolidating to strengthen their positions. Primary care groups are growing, and PPOs are beginning to convert to HMO and point-of-service models."

"Given the tremendous diversity that exists within the physician community, these changes have had a widely uneven impact," Dr. Hamilton said. "Some of us have benefited; others have not. Some physician groups practices are willing and well-prepared to contract with payers [in capitated systems], others are not."

To assert control, physicians must first be willing to change, said William Grundler, MD, medical director for Suburban Heights Medical Center, a physician organization in Chicago Heights. He said he believes such statements as "capitation takes away control" are myths, adding that capitated systems can be refined to make them more controllable, which is what his group did.

Dr. Grundler advised physicians interested in establishing a multispecialty group to form a task force to develop the ground rules under which the group will operate, to seek medical and legal advice and to be willing to invest their own money. "It doesn't take a lot of capital," he said.

In addition, physicians will be able to get help from the ISMS PSO – "a portfolio of products that will offer value to all physicians," Dr. Traugott said. The PSO will support physicians based on their individual needs, he added. "For example, while a solo practitioner may be concerned about whether he or she

should join with another group, members of larger groups may want to work with the PSO's consultants to establish better governance practices, compensation arrangements or office procedures, or to improve their information management capabilities.

"Like PSOs and MSOs being developed across the country, the proposed ISMS PSO would create an infrastructure for practice management and managed care contracting," Dr. Traugott said. "But unlike other PSOs in Illinois, the ISMS PSO would be physician driven, physician designed and physician directed." ■



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REPORT for Illinois Physicians

ILLINOIS MEDICARE PART B

On January 1, 1996, the Health Care Financing Administration, through its Medicare carriers, implemented a national correct coding initiative. The goal of this initiative is to identify and eliminate the incorrect coding of medical services. This initiative has been implemented via the installation of a set of new "edits" into each carrier's automated claims-processing system.

The new package of claims-processing "edits" focuses primarily on comparing the CPT codes for those situations where two or more services are provided to one beneficiary on the same day. These edits identify situations where outdated codes are being used, the CPT definitions for some services may have been misunderstood or misinterpreted, mutually exclusive procedures have been coded together, or simply a mistake has been made in the coding. Additionally, a new "GB" modifier has been established to help the Medicare carriers identify when distinct procedures have been performed by the same physician on the same day. Appropriate use of this modifier permits payment for services that would otherwise be deemed as incorrect coding.

Physicians and others who have been correctly coding for their services and routinely keep abreast of changes in the CPT coding system should experience little or no disruption in the processing of their Medicare claims.

HCFA developed the new package of "edits" under a contract with a Medicare contractor. The contractor reviewed the code definitions for all CPT codes. In addition, HCFA sought the advice of a broad range of physicians and specialists concerning current standard medical and surgical practices. HCFA will be making periodic revisions and updates to the coding package, and therefore encourages physicians to work through their local specialty societies to make suggestions concerning corrections and/or improvements to this initiative.

Any questions you may have about specific claims or this initiative should be directed to the Illinois carrier.

HCFA's National Correct Coding Policy Manual can be ordered by calling the (703) 487-4650 for the base manual (PB96-957699LMJ) or diskette (PB96-500111LMJ). Updates to the base manual (PB96-957600LMJ) can be obtained by calling (703) 487-4630.

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EDITORIAL

Keeping afloat on the Internet

The Internet is everywhere. Not only is the information superhighway itself extensive, but its users – estimated by America Online to be more than 5 million people in the United States and 30 million worldwide – come from every age group and every profession, including medicine.

For the feature story in this issue, Illinois Medicine talked to some physicians about how they're using the Net. Through newsgroups, doctors are talking to their colleagues about cases, techniques and procedures. One physician posts a case, including X-rays and ultrasound images, once a week, and the following day he receives comments from as many as 50 doctors. Physicians also use the Net to access research and seminar information related to their specialties.

Applications can be practical as well as strictly clinical. For example, another doctor said he regularly downloads key data to plug into lecture notes and handouts.

Consumers, too, can get medical updates by surfing the Net, but they need to make sure they don't wipe out in the process. A physician interviewed for the story said patients should make sure that advice they follow comes from recognized health-related institutions, since pages generated by other individuals or groups can be subjective.

That concern was also raised in the Jan. 29 issue of Interactive Week, a magazine devoted to the Internet. An editorial said, "The fever-pitch spread of

health-related sites is rapidly turning the World Wide Web into a virtual ER." The writer listed several sites that encourage patients to be diagnose-and-treat-yourselfers – from caring for bee stings to diagnosing lower back pain to administering the Heimlich maneuver on a loved one. Many of the sites carry such disclaimers as "[We] neither endorse nor are qualified to endorse any of the ideas or products found among these links. [We] have not even read every document accessible by these pages."

If, as studies indicate, many consumers don't read the directions on their prescriptions, what are the chances they'll read on-line disclaimers? The editorial warns that by "empowering every surfer, medical sites give us license to administer [medical care] to ourselves."

Another potential problem for patients was reported in the Wall Street Journal. A community health clinic in West Virginia is putting patient records on the Internet. That way, when patients are admitted to emergency departments on weekends, doctors can readily learn about chronic conditions or drug allergies. But the drawbacks – such as the potential for unauthorized parties to tap into those confidential records – could be considerable, according to the Center for Democracy and Technology, in Washington, D.C.

Like every technological development, the Internet carries the potential for advances and misuse. Let's hope our patients aren't harmed by the latter. ■

PRESIDENT'S LETTER

The thrill of medicine, the agony of ...

Raymond E. Hoffmann, MD



The mini-interns commented on how important it was to see us in that role of patient advocate.

Winnebago and many other counties have recently held their annual mini-internships. This program, spearheaded by the ISMS Alliance, is an excellent introduction to medicine for those in professions that interact with ours. Every mini-intern is assigned to a physician to observe a doctor's typical working day. Then there's usually a wrap-up dinner at which all share their stories and experiences for the day. This year, as in all past years, the amazement shared by those outside the profession was wonderful.

It is hard to explain what we do to people and for people. When patients come to us, they are concerned about their own health and have little interest in getting an overview of the practice of medicine. However, when someone spends a day trailing around behind us, they see the myriad problems we encounter. Years ago, then-state senator Joyce Holmberg pointed out how impressed she was by the social, moral, ethical and financial concerns doctors faced just to get good health care for patients. That theme was echoed this year as the interns saw us struggle to balance cost with care.

I think we often forget how wonderful this profession is. We all become physicians to help people in need. The mini-interns commented on how important it was to see us in that role of patient advocate – standing up to insurance companies and helping uninsured patients get the care they need.

Not one mini-intern mentioned anything about the business of medicine; they expressed only concern about caring for the uninsured. When people see us in our practice setting, they understand the constant attention we give to the medical side of our profession, trying to offer quality care within any financial arrangement. Sure, years ago we had to figure out how to afford to pay tuition and living expenses as we put off earning money for years on end. But our

motivation was not financial; it was intellectual.

During the last few weeks my children have started working with patients. My son, in medical school, called me four times, ostensibly to ask about buying an otoscope. Most of us have them (sitting on shelves and no longer being used). He didn't really want to talk about that, though. He just had to share his exhilaration and fascination with his first clinical experience. He was so excited that he was the one to tell a young woman that she was pregnant. My daughter is experiencing a similar thrill as she starts studying language acquisition in toddlers as part of her psychology research.

FOR MANY OF US, those feelings of newness and excitement we had when we were younger are lately being overshadowed by everything happening in our practices. We have to fight for patients' rights in the legislature. We have to fight the insurance companies for coverage of necessary treatments. We have to experience fear of a lawsuit each day. ISMS has had to form a whole new company, the Physician Services Organization, just to help physicians continue to give high-quality care regardless of their practice structure. With all these concerns, it's no wonder our attitudes have hardened.

We cannot let this agony get us down, though. Perhaps all of us should become mini-interns or stop and listen to the excitement of a new medical student, just to get refreshed and remember our early days. We had the same exhilaration, and if we look hard enough, we still do.

My personal goal has been to leave future generations the good things about medicine. If all we leave behind are our amazement and wonder at helping our fellow human beings, our successors will continue to find ways to offer quality care. ■

GUEST EDITORIAL

Animal rights and AIDS

By Joseph E. Murray, MD

Copyright, 1996, Joseph E. Murray, MD

The recent experiment to transplant bone marrow cells from a baboon into a human AIDS patient has already drawn one conclusion: Americans must decide whether they support animal research or "animal rights." It is impossible to do AIDS research without animal experimentation.

Even before Jeff Getty entered San Francisco General Hospital for the procedure, the public relations machinery of People for the Ethical Treatment of Animals, the Humane Society of the United States and other groups that take the extreme "animal rights" view went into high gear with the message that humans have no right to interfere with animals, even if lives are in the balance.

In commentaries, letters to the editor and TV news sound bites, animal activists blasted researchers' latest attempt to find an effective treatment for AIDS. The offensive against scientific inquiry comes as no surprise. Six years ago, PETA's founder, Ingrid Newkirk, told a magazine reporter that if animal research resulted in a cure for AIDS, "we'd be against it."

Animal activists oppose all animal-based medical research. If we had listened to their arguments 50 years ago, children would still be contracting polio. The polio vaccine was developed in monkeys. Diabetics would not have insulin, a benefit of research on dogs. We also would be without antibiotics for pneumonia, chemotherapy for cancer and surgery for heart diseases, organ transplants and joint replacement.

Today, once again, the animal activists are wrong. And we can't let a potential treatment for AIDS fall victim to the specious animal rights rhetoric.

Jeff Getty volunteered without any assurance that the transplant would extend his life. In the noblest tradition of scientific investigation, he hopes that his experience will increase our knowledge of the human immune system.

This is not just about AIDS and Jeff Getty's immune system. The knowledge gained from this experiment could have

an impact on cancer therapy. The research almost certainly will enable doctors someday to treat leukemia, aplastic anemia and lymphoma patients with human bone marrow that is less than a perfect match and to open the pool of potential organ donors to include animals.

Animal activists condemn the Getty experiment as morally wrong because the baboon donor was killed.

The baboon donor, raised in captivity for research, was fully anesthetized while the marrow cells were drawn. The animal was sacrificed then because all tissues had to be preserved for further scientific study. When the procedure moves out of the experimental phase, scientists will be able to harvest the necessary cells without sacrificing an animal.

For all its potential, there are no guarantees that the procedure will work, that the transplanted cells will take hold in Getty's system or that they will increase his immunity. Nor are there any guarantees that he will be safe from baboon diseases.

Medical research is a lengthy, highly risky and expensive process with no certainties. Without taking the time, braving the risks and paying the costs, there can be no success. The Getty experiment is an important step in this ongoing process.

The public should understand that medical researchers are working for the health of us all. They should not be diverted from that essential purpose by irrational "animal rights" demands.

As we approach the 15th anniversary of the discovery of the AIDS virus, it is not enough for us to wear red ribbons and hope that a cure is found. We must actively support those who are on the front lines of research. ■

Dr. Murray, a professor emeritus at Harvard Medical School, received the Nobel Prize in 1990 for his breakthrough research on transplants. He is on the board of directors of Americans for Medical Progress, a national organization based in Alexandria, Va., that promotes and protects animal-based medical research.

ISMS to sponsor free clinic workshop

ISMS will sponsor a free clinic workshop Saturday, March 30, in Springfield. The program will be held from 10 a.m. to 5 p.m. at the First Presbyterian Church, 321 S. Seventh St., adjacent to the Health-First Community Clinic.



The workshop is open to all physicians, directors and volunteers who work in established free clinics in Illinois. A panel discus-

sion will cover such topics as physician recruitment, fund raising, administration, liability and insurance, followed by a question-and-answer session and a tour of the clinic.

Keynote speaker Kevin C. Kelleher, MD, of Roanoke, Va., who helped establish one of the nation's first free clinics, will discuss the future of free clinics.

The registration fee is \$10 per person. To register or get more information, call (800) 782-4767, ext. 1387. ■

Quotables

"Now there's a gold rush for primary care physicians. It's like McDonald's going out and buying all the best corners. There is a shortage of good retail locations. That's why the price is up."

— Health care information consultant **Michael Sachs**, describing the appeal of primary care practices to potential purchasers like hospitals and insurance companies, *Chicago Tribune*

"The question is, Is it worth it? Are we putting these people through agony for nothing? We don't know the answer yet."

— **Alvin Tierstein** of Mount Sinai School of Medicine in New York City, on lung volume reduction surgery for emphysema patients, *Newsday*

"To lose sight of just how lucky we are to have a profession in which we do well for ourselves by doing well for others reflects a puzzling loss of perspective."

— **C. Eisenberg, MD**, *New England Journal of Medicine*

"I think [estrogen] does promise to significantly reduce the incidence of Alzheimer's disease in women."

— **Stanley Birge**, clinical director of the aging program at Washington University in St. Louis, on evidence that estrogen may help protect women against Alzheimer's disease, *Associated Press*

"It became apparent to payers that treatment usually ended, particularly with substance abuse, when the limit was reached on one's insurance coverage. Patients always got better on the 30th day."

— **William Goldman, MD**, medical director of U.S. Behavioral Health, on the arbitrariness of month-long stays at psychiatric hospitals, *Time*

"If we had forever been doing managed care and were now going into fee-for-service, we would have similar fears. Physicians would be saying, 'What do you mean I only get paid if patients come in?'"

— **Kenneth Davis, MD**, on physician resistance to managed care, *Texas Medicine*

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ISMIE Update

ISMIE introduces physician business practice liability insurance

New policy covers physicians for exposure unrelated to patient care.

BY KATHLEEN FURORE

Physician liability is changing and growing as managed care escalates in Illinois. To help protect doctors from these new risks, ISMIE recently introduced a physician business practice liability policy that protects them from legal exposure in areas that medical malpractice insurance doesn't cover, said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors.

"ISMIE put this product in place because life has really changed for physicians," Dr. Jensen said. "Out of necessity, they're going into areas and activities that aren't directly related to patient care, which means they have different liabilities than the risk created by treating patients. They also have business liabilities that result from the increasing emphasis on the business side of health care delivery."

The physician business practice liability policy is available to physicians who practice in clinics or corporations and are insured by ISMIE for medical malpractice. "This coverage will become a primary component [of a physician's liability insurance portfolio]," an ISMIE analyst said. "A doctor could be sued without ever touching a

patient. But with both ISMIE policies, doctors don't have to worry about how a plaintiff comes at them."

"A medical malpractice policy covers hands-on rendering of patient care," said Bonnie Lederman, who helped develop the policy and is a partner in the Chicago law firm Peterson & Ross. "This policy is designed to give broader coverage."

The coverage would, for example, protect physicians who determine the appropriateness of certain medical procedures for managed care entities. "A doctor might be deciding if the plan should pay for a particular treatment — a bone marrow transplant or emergency condition," Lederman said. If physicians decide a treatment should not be covered, they could be sued by the patient, the managed care organization or both, she explained. "This is the type of situation that might be covered under the new ISMIE policy."

The ISMIE analyst gave another example of liability related to utilization review. "A doctor might decide Prozac is approved for three conditions. But if a patient has a fourth condition that could have been treated with Prozac and as a

result of not being treated with it is harmed, the patient could sue. The decision as to the protocol is what makes you liable and ostensibly caused the harm. And that is not covered by a medical malpractice policy."

Or physicians who credential doctors for HMOs could face a lawsuit if someone they credential allegedly harms a patient, according to the analyst. "A doctor could be sued by the HMO or the patient because he designed the parameters that allowed that doctor in."

ISMIE's policy differs from similar coverage offered by other insurers because it is physician-specific. "Most companies used bank [directors' and officers'] policies and adapted them for managed care entities," Dr. Jensen said. D&O insurance covers a company's managers and owners for liabilities incurred by the organization. "But what physicians need is

Risk management seminar for office personnel scheduled

ISMIE is again offering a seminar on office risk management to be held at various sites throughout the state from mid-March through early November. The sessions focus on how office staff members can implement effective risk management procedures to help physicians provide better-quality medical care, prevent patient injury and reduce the chances of being sued.

Each three-hour seminar will cover communicating with patients to prevent patient injury and litigation; documenting, accessing and retaining medical records; developing effective office pro-

cedures for patient follow-up; navigating managed care issues; and billing and collection. The sessions are recommended for physicians, office managers, nurses, receptionists, business managers and all other medical staff personnel.

Attendees must register by mail to guarantee a seat at the seminar. Each session costs \$10, which covers materials. The programs start with a continental breakfast at 8:30 a.m., followed by the seminar from 9 a.m. until noon. For more information or to obtain a registration form, call ISMIE's risk management division at (312) 782-2749 or (800) 782-4767. ■

not what banks or businesses need," he explained. "Physicians' exposure and liability are different. We designed this policy specifically for our insureds, our physicians. It defines quality assurance, peer review and utilization review and provides

protection for these activities. Those terms are not defined in a lot of other policies."

Watch upcoming issues of Illinois Medicine for information on more new ISMIE products and services. ■

MALPRACTICE ROUNDUP

Staff meeting minutes ruled safe from subpoena

A federal district court in Kansas ruled that the minutes from the monthly staff meetings of the Ob/Gyn department at a hospital in the state were privileged and not discoverable by a malpractice plaintiff, reported the November 1995 issue of Health Law Digest.

The plaintiff had obtained a subpoena ordering the hospital, which was not named as a defendant in the suit, to produce all original meeting minutes dating from 1990 to the present. The hospital objected, alleging that the minutes were prepared, in part, to meet peer review and risk management requirements imposed by Kansas laws, and that state law protects such documents from discovery and subpoena.

The federal district court ruled that the hospital could claim the peer review and risk management privileges and sustained the hospital's motion to modify the subpoena, deleting the direction to produce the minutes, according to the story. ■

Failure to take blood count results in \$12 million award

A Chicago jury returned a \$11.96 million verdict against a physician and a hospital for failing to diagnose a patient's blood disorder. As a result of that disorder, the patient suffered a stroke that left him paralyzed and aphasic.

The plaintiff, a 29-year-old hospital employee, had been experiencing headaches and visual disturbances when he saw the defendant physician, who had a contract to treat hospital employees, reported the December 1995 issue of Malpractice Law & Strategy. The physician did not perform a blood count, which would have led to a diagnosis of polycythemia rubra vera.

The defense claimed that the blood disorder was exceedingly rare in people under age 30 and that therefore there was no reason to suspect it. ■



Amy Rothblatt

ATTORNEY Jeffrey Goldberg (center, clockwise), structured-settlement consultant Casey McCarthy and attorneys Maurice Garvey and Patricia Bobb participate in a Feb. 8 seminar on resolving medical malpractice cases through mediation and co-mediation. The program was held at the Prudential Plaza in Chicago.

TECHNOLOGY

Doctors dive into the Internet

Physicians consult with colleagues and access the latest research.

BY JANICE ROSENBERG

Before physicians surf the Internet, they have to get their feet wet. Their approach varies: Some stick just a toe in; others wade in a little at a time; and still others dive in headfirst. But regardless of the type or degree of immersion, the Internet is eventually useful to just about everyone who tries it. Through it, physicians can consult with colleagues all over the world, gain access to the latest research on drugs and diseases, find conference information and exchange images.

"It's important that every physician has an understanding of how computers can be helpful in their practice," said Ronald Sirota, MD, president of the Chicago Pathology Society. "In the future there are going to be applications on the Internet that we have not yet anticipated that will substantially improve practice, facilitate the exchange of information and benefit all of us."

In the United States, the Net evolved from a military research program in the late 1960s. As recently as 1981, only about 200 computers were connected to the Internet, but today that number exceeds 5 million, according to America Online. Worldwide, the number of people with access to the Internet is more than 30 million.

Physicians who want to get started on the Internet need a computer, a modem and a server. A university affiliation offers doctors one of the easiest ways to go on-line. Commercial on-line services like America Online, Netscape and Prodigy also provide easy access to the Net, as do such local servers as Interaccess in Chicago. Costs vary, usually based on the amount of time spent on the Net.

David Loiterman, MD, a vascular surgeon at LaGrange Memorial Hospital, has been using the Net for about two years. He increased his involvement gradually, starting with a search for literature related to a research project.

Dr. Loiterman decided to try accessing Medline from his own computer. After signing up with a local server, he found what he was looking for – and more. "When I saw how easy it was, I began using it once or twice a week to find current literature on questions that came up in the clinic," he said.

Pretty soon, Dr. Loiterman was surfing the Net – or as he puts it "poking around" – looking for ways to connect with other surgeons. Eventually he found a Usenet newsgroup designed by a surgeon at the University of Toronto.

Usenet newsgroups are free electronic bulletin boards on which subscribers can post and read messages. Usenet was started in 1979 as an experiment at the University of North Carolina. By 1989, it includ-



Rick Kroninger

ed 450 newsgroups, and today there are more than 16,000, each focusing on a specific topic.

Dr. Loiterman joined Surginet, a newsgroup with two divisions and 500 members worldwide. Through the newsgroup, on-line colleagues anonymously discuss cases, techniques and procedures 24 hours a day, seven days a week. About once a week Dr. Loiterman posts one of his own cases along with X-ray and ultrasound images. The next day he finds comments from as many as 50 physicians.

Information on specific topics can also be accessed on the Net with help from the World Wide Web, a powerful software scheme designed for electronic publishing. Its hypertext markup language makes it easy to combine and "publish" complex types of data that can be read by any computer. The Web also adds structure to the Net, allowing those who use it to navigate its fragmented resources.

ONE OF THE BEST THINGS about the Internet is that you can use it without understanding how it works. Once you plug into the Net, the software asks for a subject. Simply type in a keyword – anything from angina to zidovudine – and you are almost certain to find a suitable "home page" or "site" on the Web.

Typing "pathology," for instance, will lead you to numerous relevant sites including the Chicago Pathology Society's Web page. Created by Dr. Sirota and Enric Solans, MD, assistant professor of pathology at Loyola University Medical School, the site offers the

(Continued on page 8)

Doctors dive

(Continued from page 7)

society's meeting schedule, an anatomic case of the month, discussion forums, local pathology news, e-mail contact and an application to join the society.

If you key in "asthma," you'll find about 50 relevant sites, according to Carl Lawyer, MD, director of the asthma program at the Southern Illinois University Medical School in Springfield. Click highlighted words or buttons on any Web page and you can "hyperlink" to related pages that open up worlds of

information.

Dr. Loiterman spends three to four hours per week at his computer and would like to spend more time exploring the information superhighway. But some physicians find a keyword search more overwhelming than helpful.

"The things I've stumbled on so far haven't been worth my time," said Regina Kovach, MD, an assistant professor in the Department of Internal Medicine at SIU Medical School. "I'd prefer to have some education about where the pertinent sites are on the Net and how one goes about getting information efficiently. Right now, I can sit in front of

the computer for 45 minutes and not come up with anything."

For those who prefer more exact directions, addresses for specific sites on the Web are available. They are entered in the same way as keywords. For instance, the Chicago Pathology Society's address is <http://www2.interaccess.com/CPS>.

Raymond Gensinger, MD, an internist and the director of medical informatics at the SIU Medical School, recommends a University of Kansas site called Medical Matrix, at <http://www.kumc.edu:80/mmatrix/>, which serves as a general guide to all sorts of medical

information on the Net.

SIU has a site for its Department of Obstetrics and Gynecology at <http://siumed.edu/ob/>. Just 11 months old, it is probably the largest site for Ob/Gyn on the Web, according to Armando Amador, MD, associate professor of obstetrics and gynecology at the SIU Medical School.

Documents on the site are viewed about 12,000 times each month, Dr. Amador said. "The hits come from all over the world, from people looking for data base information that's either considered very important or hard to come by in reproductive medicine."

The American Medical Association opened its Web site at <http://www.ama-assn.org> in August 1995. It features weekly updates from JAMA, specialty publications and American Medical News, plus access to breaking news, press releases from media briefings and statements from the AMA. The page can also link users to various other relevant medical sites.

"Excellent reference materials have traditionally played a crucial role in the practice of medicine," said Robert Musacchio, PhD, the AMA's chief information officer. "We are focusing on the capability to communicate with physicians and assist them in the challenges they face in practice on a daily basis."

Information on the Net has many practical uses. Dr. Lawyer said he spends 30 hours each week using his computer to organize clinical, research and teaching materials. "If I'm using the computer to put together a handout or lecture notes, I switch to the Net frequently to access and sometimes download key information."

David Hanson, MD, chairman of the Department of Otolaryngology-Head and Neck Surgery at Northwestern University Medical School, recently received funding for the Northwestern University Multipurpose Research and Training Center on Communication Disorders. The grant requires the center to provide interactive teaching programs for public information and continuing health care education. Dr. Hanson said he plans to create Web pages to address those issues.

PHYSICIANS ARE NOT the only ones accessing medical information through the Internet. Patients also study Web pages for the latest medical updates.

"Patients are empowered to acquire useful information by using the Net," Dr. Lawyer said. "The old-fashioned attitude that patients should be kept in the dark is reprehensible."

Dr. Amador agreed, but said Web pages generated by people other than health care professionals can be subjective. "Patients have to be very careful when they look for information, and [they should] be certain to obtain it from sites of recognized health-related institutions."

Dr. Gensinger said the Net will become particularly important for rural physicians who lack immediate access to their colleagues. "We have many graduates who have asked for access to medical information and a way of contacting physicians in Springfield for informal consultations about patients they are seeing. Technology is important, but you shouldn't buy into it for the glamour. You should use it for its functionality in improving your practice."

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Legislators voice

(Continued from page 1)

health care," said Rep. Mary Flowers (D-Chicago), a MCPRA co-sponsor. "We're micromanaging the health system, allowing the insurance companies to dictate to the doctors regarding the health of the patient." She said the bill will be an important step in maintaining professional integrity. "It will let doctors be doctors and insurance companies be insurance companies."

"Disclosure about all medical options is imperative to patients," said Rep. Sara Feigenholtz (D-Chicago), another co-sponsor of the measure. Her mother was a family physician, and Feigenholtz said she grew up seeing quality care, hand-holding and strong physician-patient relationships. She added that her mother "was trained to diagnose and treat. Never would [doctors then] withhold information on treatment or prevention."

Constituents have made their opinions clear, the representatives said. "There hasn't been a member of the

General Assembly who hasn't had a family member, friend or constituent complain about being denied access to a medical procedure they should have," Erwin said.

Many older people in Feigenholtz's district have expressed unwillingness to enroll in HMOs because of their fear of treatment exclusions, she said.

Businesses are also beginning to show support for MCPRA, according to Rep. Patricia Reid Lindner (R-Sugar Grove), a co-sponsor. "Crain's Chicago Business has endorsed it, and that shows significant support from area employers."

Erwin said she is actively working to promote the bill's benefits to businesses. "Corporations demand quality in their

own processes, and they need to demand this in terms of their insurance coverage as well. This bill will give them value for their health care dollar. Employers don't want to spend money only to discover that employees became sick later or that their condition worsened due to a bad decision."

In particular, the maternity benefits provision of the measure struck a chord with some legislators who have children, Flowers said. "When I gave birth to my daughter in 1991, I was in the hospital for four days. I would have hated for the insurance company to come in and tell my doctor what to do."

Flowers quoted an insurance lobbyist as having said, "The problem with women having babies is they don't follow protocol."

She said the statement shows the "arrogance of some insurance companies. It's really discrimination, because there's no other medical procedure that is so regulated."

Lindner contrasted her four-day maternity stay with the experiences of friends who have recently had babies: "Some have had babies who were jaundiced, sent home and then had to return to the hospital."

Without MCPRA the "rights of patient and doctor and their special relationship are being violated," Lindner continued. "Together, they must be making the choices regarding the extent of care and length of time in the hospital. There should not be a third party dictating this because it's cost-effective." ■

Judge upholds

(Continued from page 1)

on the Petrillo provision are two recent rulings to uphold that provision by Illinois circuit court judges in Winnebago and Ogle counties. "Those judges have considered the same arguments [as Judge Gillis] and held that the legislation is constitutional," Morse said.

The other provision Gillis ruled unconstitutional says hospitals are not vicariously liable for actions of doctors they do not employ. "Since [it] only attempts to eliminate the doctrine [of apparent agency] for 'medical, hospital or other healing art malpractice,' it violates the special legislation clause and the equal protection clauses of the Illinois Constitution," Gillis wrote. He also said it "violates the separation of powers provision of the Illinois Constitution, in that the Illinois courts have already provided for the rule of law in this area."

In 1993, the Illinois Supreme Court ruled in *Gilbert vs. Sycamore Municipal Hospital* that "under the doctrine of apparent authority, a hospital can be held vicariously liable for the negligent acts of a physician providing care at the hospital, regardless of whether the physician is an independent contractor, unless the patient knows or should have known that the physician is an independent contractor."

Gillis' rulings are not precedent-setting. Furthermore, the issue of the legislation's constitutionality is expected to be ultimately decided by the Illinois Supreme Court, Morse said. Dr. Hoffmann noted that ISMS and the Civil Justice League always anticipated that "every single part of the tort reform law would be challenged. But the State Medical Society and the Civil Justice League will do everything legally possible to keep the Tort Reform Act intact," he said.

Because all these recent cases are procedural rulings, it is not clear whether there is a right to appeal, Morse noted. "The judge would have to certify these decisions in order to permit an appeal. That certification would have to come at the request of one of the losing parties." When a statute is held unconstitutional, the Supreme Court is required to take the appeal, but if a statute is upheld, appeal is at the court's discretion, he added. ■



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Illinois
physicians put
patients first,
speakers say

PAGE 2

Massachusetts bans use of gag clauses

CONTRACTS: Managed care entities must let physicians discuss treatment options.

BY KATHLEEN FUREORE

[BOSTON] As of April 1, Massachusetts physicians will no longer have to worry about managed care gag clauses thanks to legislation the state's General Assembly passed in January. The new law – the first of its kind nationwide – bars commercial insurers and managed care plans from enforcing gag clauses in their contracts with providers, according to Rep. Doug Petersen (D-Marblehead), one of the bill's sponsors.

The measure prevents insurers and managed care entities from refusing to contract with or compensate health care providers who in good faith discuss health coverage with their patients, according to the Massachusetts Medical Society. After hearing testimony from physicians who expressed fear and anger over what they called blatant censorship, the state's Committee on Insurance adopted many MMS suggestions in drafting the bill, according to an MMS spokesperson.

"These contract gag clauses were a true violation of the physician-patient relationship. They interfered with physicians' legal and ethical duty to act in the best interest of their patients," said MMS President Guenter Spanknebel, MD. "Patients want and need their physicians to give them advice on insurance coverage and treatment options. Physicians should be encouraged to talk openly to their patients about their medical care, which is what House [Bill] 5347 will allow." The new law protects open physician-patient communication but doesn't allow providers to spread false or malicious information designed only to harm an insurer or managed care plan, according to MMS.

(Continued on page 11)

Proposed budget will speed Medicaid bill payment

HIGHLIGHTS: Illinois' fiscal year 1997 budget will generate more federal money and slash hospital assessments without raising taxes. BY KATHLEEN FUREORE

[SPRINGFIELD] In a March 6 address to the General Assembly, Gov. Jim Edgar unveiled a \$33.56 billion budget for fiscal year 1997 that will increase funds for physicians and other providers and continue easing the delays in Medicaid payments. The budget doesn't include rate increases to the physician line. The extra funds will be applied to the remaining backlog and will help keep the payment cycle low.

"We can pay our Medicaid bills on time," Edgar said. "No old bills. No backlog. We will be current and paying our bills more quickly than the state has done in at least a dozen years." He noted the proposed budget will bring "longer-term financial stability for health care providers and better access to care for Medicaid clients," and will allow the state to halve the assessments hospitals have been



Edgar

paying as part of an initiative to bring in more federal money for Medicaid.

"Physicians applaud Gov. Edgar for continuing in this budget his commitment to paying the state's Medicaid bills in a timely manner," said ISMS President Raymond Hoffmann,

Ron Ackerman

MD. "This commitment will make it easier for doctors and other providers to continue making quality health care services available to all the patients who rely on the program."

The proposed budget, which exceeds the 1996 budget by less than 1 percent, "will provide more money for the payment of bills, but the payment cycle will be about the same," said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. He said the current plan earmarks about \$72 million in supplemental funding for the Illinois Department of Public Aid medical provider lines and \$28 million for the Department of Mental Health and Developmental Disabilities for the care of the developmentally disabled in long-term care facilities during FY '96.

In addition, the U.S. Health

Care Financing Administration recently approved an intergovernmental transfer that is contributing to IDPA's improved financial condition, the governor's office said. The IGT enables IDPA to take some funds from Cook County's budget and flow them through the IDPA budget during fiscal 1996 and beyond. The federal government will match the portion of those funds spent on care for Medicaid-eligible patients. Then Cook County will receive its original funds plus a portion of the money available from the IGT. The balance of the IGT goes to other lines.

The Medicaid physician payment cycle has been less than 30 days for the past several months and is projected to drop to less than 25 days by June 30, 1996. "During fiscal 1997 it is expected to decline even further given

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CDC, physicians respond to case of TB exposure on Amtrak train

PUBLIC HEALTH: Federal investigation of possible TB transmission on train is a first. BY JULIE A. JACOB

[CHICAGO] The Centers for Disease Control and Prevention is investigating the case in which Amtrak passengers on two train routes – one originating in Chicago – were exposed to infectious TB in January. This is its first investigation of possible TB transmission on a train, according to the CDC.

An unidentified male passenger rode the Amtrak train Jan. 19 from Chicago to Pittsburgh, then took a bus to Washington, D.C., where he boarded the Miami-bound Amtrak Silver Star, said Amtrak spokesperson Steven Taubenkibel.

Crew members on the Silver Star suspected that the man – who was coughing and spitting up blood – might have TB, Taubenkibel said. So the train, carrying about 80 passengers, made an emergency stop in Starke, Fla., and the crew con-

tacted the CDC and the Florida Department of Health, he added. The CDC sent a representative to Florida to help the state health department interview the man, who subsequently tested positive for TB and died a few days after admission to a local hospital.

The CDC is currently contacting all passengers and crew from both train routes, encouraging them to receive baseline and follow-up TB skin tests, said CDC spokesperson Michelle Bonds. To help determine the length of exposure, the CDC is also asking passengers to com-

plete questionnaires asking which train they rode and how long the trip was. Although state health departments usually conduct such investigations, the CDC is handling the case because Amtrak falls under federal jurisdiction, Bonds said.

Since the incident, Amtrak has isolated, cleaned, disinfected and changed the air filters on the railway cars used on both routes, Taubenkibel said. Unlike commercial airlines that recirculate air, Amtrak continuously pumps fresh air into its rail cars, said Amtrak spokesperson Marc Magliari. Although Amtrak can control such environmental elements, it cannot prohibit sick passengers from boarding trains because such a policy would be extremely difficult to enforce, he explained. "A person with a cough [could have] the sniffles or TB. This isn't 'Star Trek.' There's

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Illinois physicians put patients first, speakers say

PROGRAM: Women health executives hear about challenges and options in managed care. BY JANICE ROSENBERG

[CHICAGO] Illinois physicians are working together to create new options that will help them interact with managed care providers, said ISMS President-elect Sandra Olson, MD, at a Feb. 28 meeting of the Women Health Executive Network. "Physicians want quality care for their patients, and they must hold fast to that value. It is both difficult and essential to do that now with the changes that are taking place in health care."

To help physicians and patients deal with those changes, the Managed Care

Patient Rights Act has been introduced, Dr. Olson said. "In a market driven by profit, we need firm ground rules spelling out patients' rights for every managed care plan to follow." The bill, filed in the Illinois House and Senate in early February, provides that patients who receive health care under a managed care program have the right to certain coverage and service standards, she explained.

Managed care plans can exert peculiar stresses on the physician-patient relationship, according to Stephen Rittmann,

MD, a family physician in Schaumburg, who also spoke at the meeting. He said he finds it difficult, for example, when his patients have to switch from one physician to another because of changes in their HMO coverage. "Patients whom I cared for were forced to leave me due to their insurance changing." As a result, Dr. Rittmann and his five partners now participate in almost every HMO in their area, he said. "There are patients in my office who have had their insurance changed every year for the last six years, but now they have continuity [in seeing me]."

As a primary care physician, Dr. Rittmann has patient advocacy as his first priority, he said. When patients have problems with their managed care plans, Dr. Rittmann joins them in trying to make necessary changes in the system, and both he and the patient call the company, he noted.

"I've never been a gatekeeper," Dr. Rittmann said. "It insults the patient and the physician to use that term. Instead, I call myself a patient care advocate."

To support all physicians, including



Dr. Olson

Amy Rothblatt

those who work with managed care organizations, ISMS is planning to develop the Physician Services Organization, Dr. Olson said. One purpose of the PSO is to ensure that medical decisions will be made by physicians and that physicians will spend less time calling "1-800-MAY I?" she said.

"The PSO will offer physicians the information and support they need to enter the managed care arena on their own terms," Dr. Olson continued. "It will be a support system that will help them evaluate managed care contracts, among other things."

The PSO will provide consulting and network-development services; managed care operations services such as enrollment, eligibility and benefits verification; practice management assistance; and practice operations services.

At the core of the PSO is the desire to help physicians in any size practice who are seeking strategies for practicing in the managed care marketplace, Dr. Olson said. The PSO will be physician designed and directed, and will be guided by the principles of good patient care, she added.

"It's not enough to level the playing field," Dr. Olson said. "We must also play the game, make the rules – not just follow those made by others – and influence and shape managed care." ■

IMPAC Annual Meeting scheduled for April 19

The Annual Meeting of the Illinois State Medical Society Political Action Committee will take place Friday, April 19, at the Oak Brook Hills Hotel. The meeting is open to all IMPAC members and will begin immediately after the ISMS House of Delegates morning session.

Business will include the election of IMPAC Council members. Nominees for appointment or reappointment to

the council are James H. Andersen, MD, Oak Brook; Albino T. Bismonte Jr., MD, Gurnee; James A. Bull, MD, Silvis; Alfred J. Clementi, MD, Chicago; Norman R. Johnson, MD, Pekin; Janis M. Orłowski, MD, Chicago; Aldo F. Pedroso, MD, Chicago; Albert W. Ray Jr., MD, Joliet; Biswamay Ray, MD, Chicago; Ronald J. Simone, MD, Geneva; and Arthur R. Traugott, MD, Urbana. ■

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U of I to study care of suicidal older patients

[URBANA] Researchers at the University of Illinois at Urbana-Champaign will distribute a survey about elderly suicide to some 800 Illinois physicians in late March, according to Mark L. Kaplan, DrPH, one of the study researchers. "Physicians' Management of Elderly Suicide: A Survey of Attitudes, Knowledge and Practices" is designed to determine the extent of physicians' ability to recognize and address signs and symptoms of suicidal behavior in their older patients. The survey will target physicians in internal medicine, family practice and geriatric psychiatry, since they are more likely than other doctors to see older patients, Kaplan said.

Such research is needed because so little is known about how physicians manage suicidal older adults, even though that age group is at highest risk, he added.

"One disturbing figure found in the literature [about suicide] is that as many as 75 percent of older adults had seen a physician shortly before their deaths," Kaplan said. "And one of our colleagues found that 20 percent saw a physician within 24 hours, 40 percent within one week and 70 percent within one month of their deaths. Those figures show how critical it is for physicians to know as much as they can about the signs and symptomologies [of suicidal thoughts and behavior]."

Kaplan also cited figures from the Jan. 12 issue of the Morbidity and Mortality Weekly Report from the Centers for Disease Control and Prevention. They showed a 9 percent increase in the number of elderly suicides between 1980 and 1992 after a decade of decline.

The survey asks physicians their approach in assessing the mental health status of patients age 65 and older, the most common mental health problems in those patients, the frequency with which they refer elderly patients to mental health specialists, the factors that make it difficult for them to meet the mental

health needs of these patients and the kind of training in suicide risk assessment they've completed.

ISMS endorses the survey and urges physicians to participate in it, said Ronald G. Welch, MD, chairman of the ISMS Board of Trustees. "Suicide is one of the leading causes of death in the United States and a serious potential outcome of mental illness," Dr. Welch wrote in a letter to survey participants. "Because seniors tend to consult their physicians regarding depression and loneliness, and in some cases do so inadvertently, we as clinicians must understand the medical and socioeconomic aspects of aging and address the resources available to diagnose and treat our patients and refer them as applicable."

The researchers expect to have preliminary results available by the end of May, Kaplan said. ■



Amy Rothblatt

MONIQUE HILL, project coordinator in ISMS' specialty societies division, is the most recent recipient of the Society's Employee Recognition Award. She was recognized for her positive attitude and creativity and the superior quality of her work.

General Assembly addresses managed care

ROUNDUP: Measures reflect concern about patient care.

BY MARY NOLAN

[SPRINGFIELD] Several bills introduced in the General Assembly this session reflect lawmakers' concerns about the changing health care system and the proliferation of managed care entities.

Comprehensive legislation – the Managed Care Patient Rights Act – was crafted by ISMS and filed in the House and Senate. The measure would establish patients' rights to quality health care services, choice of the physician coordinating their care, confidence in their providers' advocacy, understandable information about the terms of their coverage and their managed care plans' performance in providing quality care, mandatory minimum maternity benefits, and privacy and confidentiality. Prior authorization requirements for emergency care would be prohibited.

Other managed care bills include the following:

Choice of gatekeeper

"Let the patients decide who is the best gatekeeper for them rather than insurance companies," said Sen. Howard Carroll (D-Chicago), a sponsor of S.B. 1549. The bill would require insurance companies to allow enrollees to designate as their primary care provider any physician in the plan who is licensed to practice medicine in all its branches, regardless of the doctor's specialty. Recipients of integrated benefits provided through state-administered programs would also be allowed to choose their primary care physician.

Coverage for investigational treatments

Under H.B. 3168, any new health insurance policies for individuals or groups would be required to provide coverage – when deemed medically appropriate – for patients who participate in approved research trials or who need investigational treatments for a life-threatening disease, disorder or health condition.

"The bill could save people's lives and offer hope to those who are faced with tough ordeals," said sponsor Rep. Anne Zickus (R-Palos Hills). "We need to get our medical care back into the hands of doctors. If the [insurance] industry is not going to solve [the problems in health care today] and there is sufficient public interest for action, then we have to legislate it." Her bill does not include health care services funded by such sources as research grants from the state or federal government, large universities or pharmaceutical companies. If enacted, H.B. 3168 would become effective Jan. 1, 1997.

The dentist-patient relationship

"Dentists are facing the same problems as doctors in managed care," said Rep. Kay Wojcik (R-Schaumburg), a sponsor of H.B. 3125. "The insurance industry is dictating how they should act and what they should do." The measure would reduce third-party interference in the dentist-patient relationship, prohibit plans from requiring dentists to perform

procedures for which the dentists believe they are unqualified and ban the use of gag rules.

Consumer focus

H.B. 3262 aims to provide health care consumers with access to medical care, affordability and confidentiality of their records. It would let consumers receive understandable and current information, choose their own gatekeeper, obtain emergency care without prior approval and challenge decisions that affect access and quality. Under the measure, managed care plans would be required to use performance standards and outcome-

based quality standards. In addition, utilization review agents would be required to be supervised by licensed health care professionals experienced in the relevant field.

"The thrust of this bill is to try to make sure that we stay focused on the consumer," said sponsor Rep. Thomas Dart (D-Chicago). "It has been my unfortunate experience that most of the decision-making mechanisms that have been set up in the health care industry have all been motivated by profit as opposed to what is best for the consumer – the person who is in actual need of health care."



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REPORT for Illinois Physicians

INDICATIONS, TYPE OF SURGERY SELECTION, AND OPTIMUM LENGTH OF STAY FOR CHOLECYSTECTOMY

It is estimated that approximately 10-15% of the adult population, or more than 20 million people, in the USA have gall stones, and more than 600,000 patients undergo cholecystectomy yearly.

Most patients with gall stones remain asymptomatic for many years, and may in fact, never develop symptoms. However, gall stones may cause problems varying from mild biliary pains to potentially life-threatening complications such as acute cholecystitis, pancreatitis, or rarely cancer of the gall bladder.

Therefore, it is vital to appropriately select those patients for cholecystectomy who would actually benefit from surgery.¹ The following points should be kept in mind.

- It is well accepted in the medical profession that only patients with symptomatic gall stones should be considered for surgery
- Patients with actual biliary pain, described as relatively severe, episodic, epigastric or right upper quadrant pain, lasting one to five hours, and often waking the patient at night, will receive the most benefit from cholecystectomy
- Patients with atypical pain patterns or painless dyspepsia (fatty intolerance and bloating) are not suitable candidates for cholecystectomy
- Efficacy of surgery for acalculus biliary pain has not been established
- The patient should be able to tolerate general anesthesia, and should not have serious cardiopulmonary diseases or other co-morbidities that contra-indicate surgery.

Because of improved surgical techniques, better anesthesia, better management of co-morbid conditions, and better surgical outcomes, the role of oral dissolution therapy, extra-corporeal shock wave lithotripsy, and contact dissolution therapy, has been diminished and is limited to patients who have significant co-morbidity that precludes surgery, and to those who choose to avoid surgery.¹

Laparoscopic cholecystectomy is now the preferred surgical approach, and has been proven to be safe, cost-effective and quality enhancing.¹ Same day discharge after laparoscopic cholecystectomy has become common in medical practice.

Open cholecystectomy may be the preferred choice in patients with generalized peritonitis, suspected or known right upper quadrant intra abdominal adhesions, septic shock from cholangitis, severe acute pancreatitis, cirrhosis of the liver with portal hypertension, severe coagulopathy, known cancer of the gall bladder, and cholecystoenteric fistulas.¹ Open cholecystectomy is also indicated if the patient is the third trimester of pregnancy.¹

Many patients undergoing open cholecystectomy can be safely discharged from the hospital 24 to 48 hours after the operation.² Early discharge is even feasible in many patients who undergo cholecystectomy for severe acute cholecystitis, severe chronic cholecystitis, and gangrene of the gall bladder.² Some patients who require common bile duct exploration, and some patients with biliary hyperamylasemia and pancreatitis, can be safely discharged 24-hours post operatively.²

¹ NIH Consensus Statement: Gall Stones and Laparoscopic Cholecystectomies 1992 Sept. 14-16; 10 (3): 1-26.

² Saltzstein Ec et.al.; Twenty-four hour hospitalization after cholecystectomy. Surg. Gynecol Obstet., Nov. 1991, 173 (5) p367-70.

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EDITORIAL

Attacking substance abuse

We're finding out more about substance abuse every day it seems. In mid-March, the results of several studies hit the newspapers. One study originally published in the AMA's Archives of General Psychiatry indicated that 20-year-olds who have a low response to alcohol face a higher risk of becoming alcoholics within 10 years, reported the New York Times. Researchers from the University of California at San Diego said the participants' response levels were strongly related to their family histories, but those response levels also seemed to influence their risk of alcoholism regardless of family history.

In March, the American Academy of Pediatrics approved policy on children's use of inhalants, according to USA Today. A pediatrician interviewed for the story said that experimentation with inhalants by 7-year-olds is now a "regular occurrence." The new policy states that anti-drug programs should spell out the dangers of inhalant use beginning in kindergarten and that pediatricians and parents should know and look for symptoms of inhalant use.

The AMA Council on Scientific Affairs is predicting a surge in the number of elderly alcoholic patients by the year 2000, according to JAMA. The council wrote, "If the alcoholism rate remains constant, there will be 50 percent more elderly alcoholic patients at the turn of the next century than at the

end of the 1970s. With this increase in the total number of patients, more physicians in the United States will need to be involved in helping to prevent and treat this burgeoning problem."

In response to that prediction, the council made recommendations that have been adopted by the AMA House of Delegates. First, the AMA should work with other groups to develop guidelines for physicians regarding the prevention, diagnosis and treatment of alcoholism in the elderly, and those guidelines should be distributed to primary care physicians. In addition, medical educators at all levels should be encouraged to expand instructional materials on alcohol and aging, and foundations, universities and government agencies should be urged to sponsor clinical studies. Finally, the AMA should cooperate with such groups as the American Association of Retired Persons to develop educational programs for the elderly.

ISMS House of Delegates policy also supports the expansion of medical school and hospital training programs to help physicians-to-be learn how to help prevent and treat alcoholism. It also encourages physicians and community service agencies to expand their counseling services for alcoholics and their families.

If we follow the recommendations of these groups, we'll attack the problem from all sides, and we may be more successful at prevention and treatment. ■

PRESIDENT'S LETTER

One more question – what about the uninsured?

Raymond E. Hoffmann, MD



Fifty one percent of the premature deaths in America now come from social, behavioral and environmental issues.

Eight times this past year I've started my letter to you with a question. Each time I had the answer to that question in mind as I wrote the letter. This time, I must admit, I don't. It sure is easier to ask the right questions when you know the answers.

A short time ago we were in the midst of a great countrywide debate on the direction of health care under the leadership of Mrs. Clinton's doomed task force. One of the major issues then was trying to cover citizens without health insurance. These people could not or would not purchase insurance.

The proposed solution would have included all Americans by folding them into competing health plans administered by the government. The solution, however, was too radical a change for us. Insurance companies, employers, physicians and, finally, patients stood up and said that the plan could not work as envisioned.

That seems light-years ago when you consider everything that has happened in the interim. Managed care has come in like a whirlwind, bringing changes that were stimulated by the Clinton focus on health care and that have taken on a life of their own. Those changes have become the major concern of the same patients, physicians, payers and insurance companies.

Recently I had the opportunity to attend the National Congress of Medicine and Public Health. We spent the weekend looking at the future of the health of Americans. New concerns surfaced three years ago when the Clinton plan seemed to usurp many traditional public health efforts. And there are concerns now, with Republicans in Washington looking at ways to balance the budget and many public health agencies fearing downsizing or elimination. Another issue is managed care plan emphasis on caring for populations and assuming responsibility for preventive medicine. They are involved in cancer screenings, immunization, health promotion and so on –

but only for their covered patients.

Historically much of the advance in longevity has come from public health efforts, such as sewage control and immunizations. One of the most telling statistics from the conference was that 51 percent of the premature deaths in America now come from social, behavioral and environmental issues including violence, poverty and addiction to drugs, alcohol and cigarettes. We discussed another study that showed that if managed care entities cared only for their enrolled populations, the diseases prevalent in the uninsured people in their areas would affect the health of their enrollees.

That brings us back to my opening question. What can we do to include the uninsured in the health care system? Sure, they can get into the system via an expensive emergency. Sure, we have set up free clinics for the poor. Sure, the physicians of America can give away nearly \$21 billion in health care as they did in 1994. But none of these measures truly put the uninsured into the system.

If uninsured individuals are not cared for at all, they will experience more-serious health problems, and that will affect us all. We cannot afford to abandon them.

Whose responsibility is it? At the conference, members of a roundtable discussion group decided they were responsible collectively. This group included practicing physicians, health care purchasers, public health officers and representatives from medical training programs, hospitals and health plans. Sadly none of these major players had any firm plans.

As I mentioned, this time I don't have an answer either. I just know helping the uninsured was a problem, is a problem and looks as if it will continue to be a problem. And I hope that we can find a solution out there somewhere so that all Americans can have equal access to high-quality health care. ■

GUEST EDITORIAL

MSAs will preserve patient rights

By Robert F. Hamilton, MD

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Several economists and legislators have proposed medical savings accounts to address the rising cost of health care. MSAs would give the patient an incentive to spend health care dollars wisely, while preserving quality of care and patients' rights to choose their physicians, hospitals and treatment.

The proposed MSA legislation, allowing pre-tax contributions and withdrawals, has 137 bipartisan co-sponsors. Under MSAs, health insurance would cover major illnesses, while MSAs would cover minor health care costs.

High-deductible catastrophic health insurance premiums are much less expensive than low-deductible premiums. The employer would purchase high-deductible health insurance annually for employees. The money saved from the difference in premiums would then be placed annually into a tax-free MSA to be used by the employee for medical expenses until the deductible was met. The catastrophic insurance would pay for major medical costs.

Since the account would belong to the employee, there would be an incentive to conserve the MSA. Unspent funds would remain in interest-bearing accounts. Withdrawals for nonmedical purposes would be taxed and penalized.

Only 5 to 10 percent of the work force would reach the deductible in any year. Because most people do not have large medical costs, the accumulated MSA fund would usually equal the deductible in two to three years. Patients could make choices in a system with built-in cost incentives. MSAs would not require complicated billing forms. Managed care mechanisms could be incorporated into the catastrophic insurance portion of the plan. MSA funds would be managed by banks, insurance companies and other financial institutions.

Medicare patients would have the option of using their Medicare funds to buy a catastrophic insurance policy and make a sizable contribution to a tax-free MSA. Payments for care exceeding the deductible would be paid by the catastrophic insurance carrier.

Some strengths of MSAs are reduced health care costs, savings for employers and individuals, post-retirement savings for medical and nonmedical expenses related to nursing home care, increased availability of investment funds, preservation of patients' choices, price negotiation by patients, insurance coverage between jobs, fewer uninsured patients, preservation of the doctor-patient relationship, preventive care and a buffer against real and potential abuses by managed care entities and government-sponsored plans.

Most criticisms of MSAs are unfounded. One is that they would be attractive only to the healthy and wealthy. An actuarial study by Milliman and Robertson Inc., reported in the Wall Street Journal, has shown that MSAs would often be financially attractive to people with expected high health care costs. In addition, people who have significant illnesses are more likely to value choice of physician and hospitals than do many healthier people.

The criticism that patients would neglect needed services conflicts with the observed use of preventive care measures by employees of companies with innovative plans similar to MSAs. Some people might be better suited for managed care plans or government-sponsored programs. But who should decide this, patients or the government?

MSAs may seem unconventional, but they can reduce costs efficiently without sacrificing vital elements of medical care through a system of built-in, personal, cost-effective incentives. The MSA concept must be presented openly to the American people and not misrepresented. To finesse the public on this important issue would subvert the democratic process.

Dr. Hamilton is a general surgeon in Alton and an ISMS Sixth District trustee.

LETTERS

Coding coverage didn't go far enough

Although the article "HCFA implements new Medicare coding policy" (March 1 issue) was factually correct and mentioned the medical community's concerns about the Correct Coding Initiative, it did not address the avalanche of protest voiced by the American Medical Association and most specialty societies.

The story states that AdminaStar – the Indiana Medicare carrier, which developed the new national system of coding edits – "distributed a draft of the revised policy to physician specialty societies through the AMA" but does not indicate that policy reviewers noted thousands of inaccuracies, inconsistencies and frank cases of fraudulent overbundling. The AMA and numerous specialty societies strongly recommended to the U.S. Health Care Financing Administration that the implementation of the CCI be stopped or postponed until the document more closely reflected accurate coding and current medical practice.

I am a member of the AMA CPT Advisory Committee and the American Society of Plastic and Reconstructive Surgeons CPT Committee. A detailed analysis of the top 100 CPT codes performed by plastic surgeons has found that more than 90 percent of the coding edits within the correct coding initiative are incorrect and do not conform to standard medical practice. Other

specialty societies are finding comparable inaccuracies.

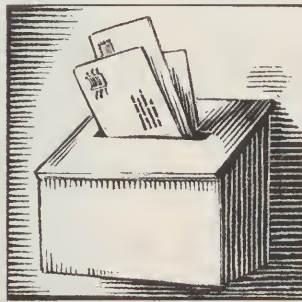
Despite the articulation of such serious concerns, HCFA instituted the CCI for all Medicare claims effective Jan. 1, 1996. No period of public comment was provided, as is required by law.

The CCI is flawed, as are most "rebundling" software packages currently in use by insurance companies. The insurers' good intentions to prevent unbundling by an unscrupulous few are more than outweighed by their systems' poor designs, which overbundle procedures and are unfair to the majority of practitioners who code correctly and honestly.

– Raymond V. Janevicius, MD
Elmhurst

Editor's note: On March 5, Illinois Medicine received word that HCFA has agreed to work with an AMA-proposed committee – the Correct Coding Policy Committee, of which Dr. Janevicius is a member – to obtain comments and recommendations regarding the CCI. The committee will help ensure that medical specialty societies have more time to review and comment on the proposed coding combinations, according to the AMA.

Illinois Medicine reserves the right to edit all letters to the editor.



ISMS, AMA waive dues for members in Bosnia

On Feb. 3, the ISMS Board of Trustees approved a waiver of 1996 membership dues for physicians called to military duty in Bosnia. Members may request the waiver in writing or by calling (800) 782-ISMS or (312) 782-1654.

The AMA announced a dues waiver in mid-January for its members called to active duty as part of the Bosnian conflict. AMA members should request the waiver in writing or call (800) AMA-3211.



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ISMIE Update

Watch for
coverage of risk
management in
managed care

ISMIE's new coverage protects physicians from risks of capitation

Policy will pay when medical expenses exceed capitated revenues.

BY KATHLEEN FURORE

Physicians who sign capitated contracts with managed care organizations get something besides funding per patient per month. "They also assume the risk that the cost of the services they provide will not exceed the capitated funds they receive," said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors. "To help manage that risk, ISMIE has introduced a capitation stop-loss policy that will pay them when medical expenses increase beyond what their capitated payments cover," he explained.

Dr. Jensen gave an example of how the coverage works: "If a physician manages 3,000 covered lives, receives \$1 per patient per month and no one becomes sick, there's no problem. If everyone gets sick, that's a problem. And if one patient needs a heart transplant, you've broken the bank. Even a severe case of pneumonia might break the bank. ISMIE's capitation stop-loss policy protects doctors in those situations. In essence, the policy stops the loss."

"This kind of coverage is particularly important for

physicians because they usually are in small groups and don't have the same kind of capital and surplus as a hospital does to sustain a bump in the road," said Patrick Carter, vice president of Aon Alliance for Healthcare.

Under an exclusive arrangement, Aon Alliance is writing ISMIE's capitation stop-loss policy and will do all claims and underwriting, said an ISMIE analyst. "ISMIE is working with Aon because the company offers a wide variety of products and services that will

be useful to our policyholders as more of them start to accept risk," he explained. "This stop-loss coverage is one of them."

The new policy is available to individual physicians, groups, clinics and corporations regardless of whether they carry ISMIE's medical malpractice insurance, Dr. Jensen said. Premiums are based in part on the terms of the capitated contracts and the amount of risk that physicians are willing to assume. "In return for a premium, ISMIE will cover those medical expenses in excess of a stated amount, either on a per-patient or aggregate basis. That might be \$5,000 per patient or \$25,000 for an entire year. After that we'll pick up the costs."

Physicians should be cautious when considering which stop-loss policy to buy, the ISMIE analyst said. "A capitation stop-loss component is included in many managed care organizations' capitated contracts. But you don't always know what you're paying [for capitation stop-loss] or what it's going to pay." Those terms are

clear with ISMIE's policy, he noted.

"HMOs often offer stop-loss coverage to instill physician confidence and to facilitate an initial capitation arrangement, but it is often a very short clause that is poorly defined," Carter said. "Vagueness in the insurance industry usually means you get less than you expected."

ISMIE's policy is customized to individual circumstances and applies to all capitated contracts a physician signs, the analyst said. "When you sign on with a number of managed care organizations, each might have different terms on its stop-loss coverage. ISMIE offers one product with one set of terms that is the same for every managed care contract you have. And it applies to all your contracts."

The development of new products and business relationships won't affect service, Dr. Jensen said. "Capitation stop-loss policyholders will receive service that is consistent with ISMIE's high, physician-first standards." ■

MALPRACTICE ROUNDUP

Jury holds hospital liable 18 years after baby's birth

In a case that underscores the need to keep the records of disabled minors indefinitely, a Bronx jury late last spring found a hospital agency negligent and awarded \$42 million to the mother of a young woman who is deaf and brain-damaged as a result of injuries during her delivery in 1978, according to the New York Times.

The defense argued that there were no indicators of potential delivery problems and that a forceps delivery saved the baby. But the plaintiff's attorney successfully argued that physicians involved in the girl's delivery ignored a test indicating she was oxygen-deprived before birth, failed to induce labor even though the delivery was overdue and caused bleeding in the baby's brain by using forceps. He also alleged that many of the problems arose because residents, not experienced physicians, were involved in the complicated delivery. And he said the hospital altered records in an attempt to hide mistakes that were made, the article reported.

Although the Illinois Code of Civil Procedure states that claims on behalf of children under 18 must be brought no more than eight years after an alleged malpractice, an Illinois appellate court ruled in March 1995 that the statute of limitations will never expire for permanently disabled minors, according to the June 1995 issue of Medical Malpractice Law & Strategy. ■

Woman receives \$43 million in cancer misdiagnosis case

In *Goldberg vs. Wallach*, a New York City jury awarded \$43 million to a 39-year-old woman who was misdiagnosed as having cervical cancer, according to the January issue of Medical Malpractice Law & Strategy. The misdiagnosis led to a C-section performed five weeks before her due date, at which time her uterus, cervix and ovaries were removed. Her baby developed breathing problems soon after birth and was severely brain-damaged. In filing suit, the woman alleged that the physician was too aggressive in delivering the baby early and failed to get her informed consent.

During her pregnancy, several Pap smears were done, showing a precancerous condition that required close follow-up. Testing late in the pregnancy suggested she had developed localized cervical cancer. She was then referred to a specialist in her HMO, who performed exploratory surgery and subsequently recommended she have a C-section five weeks early.

The plaintiff's attorney contended that the specialist frightened the woman into having a C-section and failed to advise her of the hazards of premature delivery.

The jury awarded \$10 million to the mother for past and future pain and suffering and the loss of a normal life, and \$33 million to the child for future medical and living expenses. ■

Support available to physicians facing lawsuits

ISMIE's Litigation Support Network helps doctors over the hurdles. BY KATHLEEN FURORE

Physicians involved in malpractice litigation often experience anger, self-doubt and other emotions and stresses that can damage their interpersonal relationships. To help doctors deal with the emotional challenges a lawsuit can bring, ISMIE offers the Litigation Support Network, which is composed of physicians who can lend emotional support because they've been through the litigation process themselves, said Harold L. Jensen, MD, chairman of the ISMIE Board of Governors.

"Our network members don't give legal, insurance or medical advice or therapy," Dr. Jensen said. "They share stories of how they survived the litigation experience and offer a sympathetic ear to physicians who have been sued." They can also refer doctors to videotapes, books and other resources that will help them weather the

impact of the litigation process. In addition, spouses of physicians who have been sued are available to help family members cope with the emotions generated by a malpractice lawsuit, he said.

Any contact between doctors and network volunteers is confidential, and no written record of the communication is kept, Dr. Jensen explained.

ISMIE also offers the quarterly seminar "Taking Control: Managing Your Malpractice Lawsuit" to policyholders who have been named as defendants in medical malpractice lawsuits. The seminar, open to doctors and their spouses, covers the phases of litigation as well as ISMIE's claim management process and defense policy.

For more information, phone the risk management division at (312) 782-2749 or (800) 782-4767. ■

MEDICAL MALPRACTICE

Mediation proves less is more

In litigation, as in nature, simplicity can be a plus.

BY JANICE ROSENBERG



John Gerlach/Visuals Unlimited

In Illinois, mediation has been available for some time as a way to settle medical malpractice suits by bringing lawyers, defendants and plaintiffs together outside the courtroom. But now a variation on mediation, called co-mediation, is also being used. Both approaches offer plaintiffs and defendants the opportunity to work out their differences without facing the problems of jury trials.

The basis for both mediation and co-mediation is settlement, however, and both sides must be willing to work toward that goal. Parties are sometimes unwilling to do that if they think they have a very strong case and have more to gain by going to trial. Nevertheless, even some attorneys think the jury trial system doesn't always work well.

"The more opportunities I have to deal with parties to medical malpractice cases, the more I realize that the system is out of control," said Maurice Garvey, an attorney with 25 years' experience representing physicians and hospitals in medical malpractice cases, and a partner in the Chicago law firm Bollinger Ruberry & Garvey. "Mediation offers a wonderful potential for defense and plaintiffs' lawyers to come together, come to grips with the case and dispose of it."

Garvey spoke at a Feb. 8 conference about the benefits of mediation and co-mediation. The program was sponsored by the Healthcare Risk Management Society of Metropolitan Chicago and the Chicago law firm Lewis and Gellen.

"The process of co-mediation is unique in that there are two mediators present, one an experienced

plaintiff's attorney and the other an experienced defense attorney," Garvey said.

Co-mediation was incorporated into a mediation program begun in April 1995 at Rush-Presbyterian-St. Luke's Medical Center. The hospital was interested in starting such a program for two reasons, according to Max Brown, vice president and general counsel at Rush. First, the cost of defending medical malpractice cases has risen significantly over the last 25 years, and second, in the current system, jury verdicts are unpredictable for plaintiffs and defendants.

Rush hired Jerome Lerner, a retired circuit court judge, to serve as the hospital's mediation consultant and to develop a mediation program for resolving medical malpractice cases involving the hospital. In his 18 years on the bench, Lerner had presided over many medical malpractice trials and developed an interest in ADR.

Lerner's first step was to contact other retired judges who had presided over medical malpractice trials. Seven agreed to serve as mediators for the hospital's malpractice disputes.

As an option to mediation by one judge or attorney, Lerner suggested some cases might benefit from co-mediation by a pair of lawyers, one with experience representing plaintiffs, the other with experience defending hospitals and physicians. Both would meet with all parties to a case and attempt to resolve it. "This would avoid the concern about bias [that may occur] if only one lawyer-mediator is present," Lerner said.

(Continued on page 8)

Mediation proves

(Continued from page 7)

Last August, Lerner invited a number of litigators to attend a meeting at Loyola Law School. Two Indiana lawyers who were familiar with co-mediation spoke to the group. Before the meeting, the Chicago lawyers said they wondered whether the concept could work for medical malpractice cases. Afterward, they were sold on the concept, Lerner said.

In early December, Lerner organized a course at Loyola to train lawyers as malpractice mediators. Twenty-five lawyers attended the session, participating in simulations that introduced them to mediation and co-mediation.

To date, Lerner has organized five mediations for Rush, four of which were handled by judges only. Of those four, three reached successful resolution. The first co-mediation took place Jan. 29 and was also successful. Serving as co-mediators were Garvey and Geoffrey Gifford, a senior partner at the Chicago law firm Pavalon & Gifford.

"When Geoffrey Gifford and I served as co-mediators, neither of us acted as an advocate for either side," Garvey said. "Rather we both worked very assiduously toward listening to both sides present their case. Then we worked together to bring the sides together using our considerable experience in these matters."

About 10 days before the co-mediation, the plaintiff attorney and the

defense attorney in the lawsuit submitted to Gifford and Garvey position papers that included the case background, the opinions of their experts, the medical literature, summaries of the depositions, pertinent hospital and physician records, and theories of damages. The two attorneys read them carefully, then met to discuss what they thought were the important issues, Garvey said.

The plaintiff's attorney and the plaintiff and her husband attended the co-mediation, which lasted about five and one-half hours. Also present were the defense attorney and several representatives from Rush, including Brown and attorney Susan Wood O'Leary, director of the office of risk management and associate general counsel. The defendant physician was not present, but defendants usually do attend co-mediations, Garvey said.

As would occur at a traditional trial, the plaintiff's attorney and the defense attorney made an opening statement, giving his or her version of the case, the issues and the potential damages. Then the two sides were taken to separate rooms, Garvey said.

At that point, Gifford and Garvey practiced "shuttle diplomacy," Garvey said. "We kept going back and forth between the rooms and occasionally meeting apart from both parties to give each other our own personal assessment of how things stood and what we should do to keep the parties moving in the direction of settlement. There were times when we thought the process was not

going to work, when we thought we had reached an insurmountable impasse, but we kept at it and eventually were able to dispose of the case."

At the time of settlement, the case was at least a year away from trial, Garvey said. Although each side disclosed its experts, there was no expert discovery. Both sides saved much time and expense by settling the case at the co-mediation, Garvey said.

"I don't see any reason why this procedure should not apply equally well to any type of medical malpractice case involving a hospital, HMO, individual physician or any other potential entity," Garvey said. "To be involved in the process and see it work makes me all the more confident of my opinion. When you have an experienced plaintiff's lawyer and an experienced defense lawyer serving as mediators, the parties listen."

The co-mediation process is especially indicated when the parties are far apart, Brown said. It gives both sides a chance to be heard by a disinterested party.

Brown said he is pleased with the mediation and co-mediation program so far. "Some people say this is just a pre-trial conference, but there is a difference. The role of the judge in a pre-trial conference is not so much as a facilitator, but as a person who comes down on one side or the other and tries to encourage the other side to move. These mediators aren't making a judgment. Their role is to get the parties in the case to agree."

Mediation benefits all parties in malpractice suits, according to Brian L. Crowe, a retired judge and a partner in the Chicago law firm Rock Fusco Reynolds Crowe & Garvey Ltd. Few judges take the time to talk to lawyers in court before calling for a case to be submitted to a jury. When they do attempt to settle cases, it is usually in an environment of fear and anxiety, he said.

In contrast, when he works as a mediator, Crowe said he speaks with each side. He identifies any weaknesses in their cases and helps them examine various theories of defense. The calm, reasoned atmosphere of these sessions precludes fear and anxiety, he said.

Mediation offers other practical benefits, too. Currently, there is a three-to-five-year backlog in the courts, but mediation can be scheduled whenever both parties are ready. Trials last an average of three weeks and can cost defendants from \$10,000 to \$25,000 per week, Brown said. Mediations, however, last from three to eight hours. Lawyers and judges who serve as mediators charge about \$250 per hour, and the cost is divided between plaintiffs and defendants.

"It's a no-lose situation," Garvey said. "Even if the case isn't settled, there's no way you can come away from it without knowing more about your case. And those cases that aren't settled at mediation are frequently settled within a few months or weeks, because the lawyers have had a chance to look at their case, and in some instances they've seen that it wasn't exactly the case they thought it was." ■

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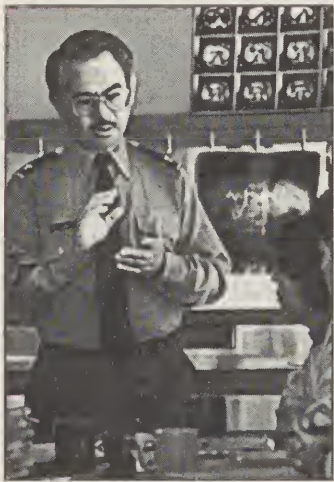
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Proposed budget

(Continued from page 1)

the proposed appropriations and projections, although it will be difficult to go below 25 days because of processing limitations," Dr. Schneider said.

"The amount of bills on hand at year-end fiscal 1996 will be about \$318 million – more than a billion dollars below the level of a couple of years ago," said an ISMS analyst.

IDPA is also budgeting for a planned increase in HMO enrollment from 170,000 to an estimated 210,000 next year, Dr. Schneider said. IDPA Director Robert Wright said, "In the next fiscal year, our plan is to offer managed care options for the first time in some Downstate metropolitan areas while continuing to expand choices for clients in Cook County."

In addition, Edgar's budget includes development of alternatives to long-term care placements as a way to slow Medicaid spending. Among those alternatives

are transitional assisted-living services and supportive living facilities. Beginning July 1, a 15-month pilot program will be introduced to test transitional assisted-living services for people who can leave nursing homes. Supportive living facilities would be phased in over the next several years for patients who do not need round-the-clock skilled care but cannot stay in their homes or independent settings. "Our goal is to improve the quality of life by giving senior citizens the choice of selecting living arrangements that offer more independence in a less-expensive environment than traditional nursing homes," Edgar said.

In the public health area, a \$502 million fiscal 1997 budget streamlines delivery of medical care for needy pregnant women and infants and boosts spending for rural health care. Transferring family case management services from IDPA to the Illinois Department of Public Health is part of the plan. "By consolidating this program under a single agency, we can

better serve clients, physicians and other health care providers. In addition, a computerized intake and tracking system called Cornerstone will help the agency more efficiently serve clients," Edgar said.

Cornerstone is a statewide management information network for Medicaid and medically indigent clients that is now being brought on-line and is scheduled to be completely in place by the end of fiscal 1997, according to Edgar's office.

Hoping to expand access to primary care medical services in underserved areas, the governor also proposed \$1.6 million in general revenue funds for grants to hospitals, community-based organizations and community health clinics. The grants could be used to open new medical clinics, to expand clinics in areas with physician shortages, to increase medical staff in medically underserved areas, to provide tuition for people training to become allied health professionals or to improve emergency medical services.

Other public health budget highlights include a proposed \$10 million in grants to 90 local health departments for basic health protection and prevention activities, \$21 million in state and federal funds for AIDS and HIV-infection control initiatives and medical care, and \$17.5 million to operate 20 WIC food centers in Chicago, said Edgar's office.

The proposed fiscal 1997 budget for DMHDD also increases the appropriation for community mental health to \$7.2 million, which will fund expanded crisis intervention services and case management. "This is the largest new spending initiative for mental health services in Illinois in the last decade," Edgar said. "It will assure that each person discharged from a state hospital is provided with an appropriate level of case management to help adjust to community living. Many of those screened for hospital admission and deflected to community treatment alternatives also will receive case management."

Massachusetts bans

(Continued from page 1)

Specifically, the bill "holds all health care providers innocent from recrimination" for openly discussing the treatment options available, even those not covered by the patient's plan. It also says managed care entities cannot stop doctors from informing patients about the plan's payment policies and the financial incentives it offers physicians. According to Petersen, the bill's original intent was to tighten confidentiality laws in the state. "But while we were working on the bill, we received

calls from providers who had been kicked off [managed care] panels for discussing coverage and treatment options with patients. So we used the bill as a vehicle to render gag clauses unenforceable."

As a result of the gag clause legislation, some insurers already "have backed off [on the gag clauses]," Petersen continued. "Providers are routinely crossing them off of their contracts."

Many other states, including New York and Illinois, have introduced legislation that would eliminate gag clauses from managed care contracts. The New York bill would outlaw gag rules in all

future HMO contracts and render them unenforceable in existing contracts.

In Illinois, ISMS recently announced the Managed Care Patient Rights Act, which was filed in the House and Senate. MCPRA "will balance the needs of patients with the interests of insurance companies that we all use to finance our health care," said ISMS President Raymond Hoffmann, MD. The measure prohibits managed care plans from using gag rules to "prohibit or discourage health care providers from discussing

any alternative health care services and providers with enrollees." It also states that patients have the right to know how a plan is structured and how it pays providers.

"It is important to have open communication if you're going to provide quality health care," said Rep. Tom Cross (R-Yorkville), the lead House sponsor of the bill. "I'm glad to hear the law passed in Massachusetts. I think it is a good sign and hopefully will help us in our fight [to ban gag rules] here in Illinois."

CDC, physicians

(Continued from page 1)

no way of screening people for illnesses before they board a train."

Donald Graham, MD, an infectious disease specialist in Springfield, said transportation and public health officials are limited as to what they can do to prevent such incidents, and "there needs to be personal responsibility."

Warning individuals with infectious pulmonary TB not to travel or be in crowds, however, is usually not effective "because the people at the highest risk of transmitting the disease either don't know they have it or are noncompliant with their treatment," said Larry Von Behren, MD, an infectious disease specialist in Springfield and an associate professor at the Southern Illinois University School of Medicine.

Noncompliance creates other problems. One is "making sure TB-infected patients complete their course of treatment so they don't come back with multi-drug-resistant TB," said James H. Andersen, MD, a thoracic surgeon from Oak Brook and a member of the Tuberculosis Elimination Task Force, whose members include Chicago-area health care professionals from different disciplines. Task force members perform such functions as directly observed therapy – personal monitoring of patients with active TB. Although such monitoring is expensive, "the alternative is unthinkable," Dr. Andersen said.

In the Amtrak situation, the CDC will analyze the data from passengers who agree to be tested to determine whether anyone contracted TB. The investigation will probably take six or seven months,

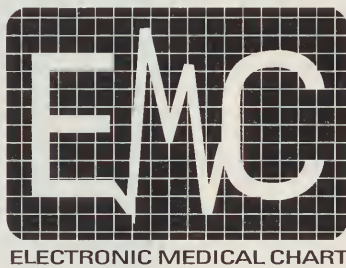
Bonds said.

It's difficult to predict whether the infected passenger transmitted the disease to other passengers, Dr. Von Behren said. "It sounds like the man was in the major, late stage of the disease, but the infectiousness is so variable, you really have to address each case individually. The probability of transmission is probably low [in this case], but the CDC would not be devoting the resources to this study if it did not think there was some possibility of transmission."

In addition, new techniques for molecular biological analysis that identify variations in strains of the disease can help epidemiologists determine whether a person with infectious TB transmitted the bacteria to other people or whether those people who test positive after exposure were infected from another source, Dr. Von Behren explained.

Although the Amtrak incident is the first CDC investigation of possible transmission of TB among passengers on a train, the CDC has dealt with similar situations in the airline industry. From 1993 to early 1995, it investigated six incidents of possible TB transmission among airplane passengers and crews, according to the March 3, 1995, issue of the CDC's Morbidity and Mortality Weekly Report. Based on its findings, the CDC concluded that the risk of transmission on a commercial flight is low.

The position of ISMS' House of Delegates calls for the Society to encourage the Illinois Department of Public Health to promulgate rules to reduce the likelihood that people with active TB will travel by common carrier and to promote physician awareness of all current TB control measures.



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Physicians lead Rockford-area IPA

HISTORY: Doctor-driven Blackhawk Area Individual Practice Association has 20-year track record. BY KATHLEEN FURORE

[ROCKFORD] When Rockford-area physicians formed the Blackhawk Area Individual Practice Association in 1976, managed care was in its infancy nationwide. But the doctors who started the physician-driven IPA suspected health care delivery would someday change and wanted to be well-positioned when that happened.

"Several physicians at that time were of the opinion that managed care might be coming, and if it was, we might as well get in there, learn and adapt our activities to it," said family physician Jesse Frederick, MD,

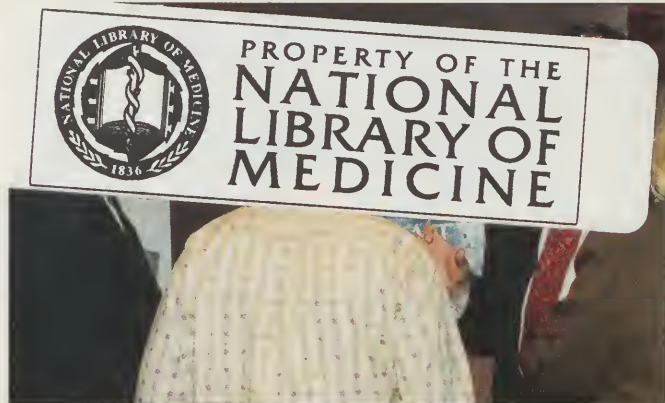
a founding member and current medical director of BAIPA. "[Managed care] was not necessarily what we would have chosen, but it's definitely beneficial that we got into it. The most desirable situation is to have physicians as a group working together, agreeing to manage themselves and bidding competitively in the marketplace."

An offshoot of the now-defunct regional utilization review organization called the Northern Illinois Foundation for Medical Care, BAIPA is a freestanding self-administered

IPA that was funded by a grant from the U.S. Health Care Financing Administration as part of a federal HMO feasibility study during Jimmy Carter's presidency, according to BAIPA president and CEO Bob Carlson. Some 450 primary care and specialty physicians spread throughout 10 northwestern Illinois counties have contracts with BAIPA, he said.

"BAIPA is entirely physician run and physician owned," Carlson continued. "It is not directly affiliated with or sponsored by any hospital, hospital system or insurer. Every doctor owns one share of stock. We think all [participating] physicians should be co-equal owners. If a doctor leaves, we buy back his share."

Participating physicians maintain their own practices, Carlson noted. "We can work with salaried doctors or solo practitioners. The physicians
(Continued on page 11)



Amy Rothblatt

ATTORNEY AND PATIENT ADVOCATE Mark Hiepler (left) and ISMS President Raymond Hoffmann, MD (right), talk to attendees on March 29 at the American Lung Association program "Patient Protection and Health Care Reform" in Chicago. Hiepler and Dr. Hoffmann were program speakers.

HIV counseling bills die in committee

PROVISIONS: Doctors would have been required to discuss HIV with pregnant patients. BY KATHLEEN FURORE

[SPRINGFIELD] Three bills that would have required Illinois physicians to provide HIV information and counseling to pregnant women failed to emerge from the Senate Public Health and Welfare Committee and the House Health Care Committee in mid-March. S.B. 1698 was sponsored by Sen. Margaret Smith (D-Chicago), S.B. 1595 by Sen. Thomas Walsh (R-Westchester) and H.B. 3175 by Rep. Maureen Murphy (R-Oak Lawn). ISMS opposed the measures because they "would have constituted unneeded intrusions on the relationships between women and their doctors," said ISMS President Raymond Hoffmann, MD.

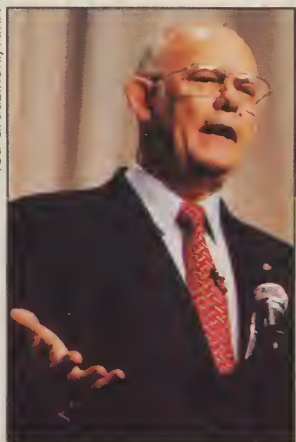
"Illinois physicians have already begun the important job of educating potential new mothers on the value of certainty regarding their HIV status," Dr. Hoffmann said. "Thanks to new guidelines issued by the

Centers for Disease Control and Prevention, we have made great progress in making physicians and expectant mothers aware of the options available. One-size-fits-all laws would compromise the ability of physicians to accomplish the intent of these guidelines in a manner that respects each patient's individual needs and circumstances."

The CDC guidelines recommend that health care providers counsel all pregnant women and encourage them to be tested for HIV as early in their pregnancy as possible. The counseling should include "information regarding the risk for HIV infection associated with sexual activity and injecting-drug use, the risk for transmission to the woman's infant if she is infected and the availability of therapy to reduce this risk," the guidelines state. In addition, they recom-

(Continued on page 15)

FORMER ISMS PRESIDENT P. John Seward, MD, addresses physicians and leaders of medical societies and group practices March 10 at the National Leadership Conference in Washington, D.C., sponsored by the AMA and the Medical Group Management Association. At the meeting, Dr. Seward formally assumed the position of executive vice president of the AMA.



Ted Grudzinski/AMA

ISMS House of Delegates will discuss PSO, managed care and public health issues

PREVIEW: Eighty-eight resolutions have been submitted for debate at the 1996 Annual Meeting.

BY KATHLEEN FURORE

[CHICAGO] As of the March 19 deadline, delegates and voting members of the ISMS House of Delegates submitted 88 resolutions to be discussed in reference committees before being debated and called for a vote on the House floor at the ISMS Annual Meeting April 19-21 at the Oak Brook Hills Hotel in Oak Brook. The resolutions cover a variety of subjects, including managed care and public health issues and

implementation of the Illinois Medical Physician Services Organization, which was developed by ISMS.

One resolution calls for the House of Delegates to "enthusiastically endorse and affirm ISMS' plans to move forward immediately with the establishment of a physician services organization." The same resolution asks delegates to actively promote the PSO in their local

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Appeals court hears oral arguments in Berlin employment contract case

UPDATE: Attorneys' comparison of physicians and nurses is challenged. BY KATHLEEN FUREORE

[SPRINGFIELD] Oral arguments in the case of Berlin vs. Sarah Bush Lincoln Health Center were held Feb. 13 in the Fourth District Appellate Court. It was the first step in Sarah Bush Lincoln's appeal of the Circuit Court of Coles County 1995 ruling that the hospital could not enforce its employment contract with general surgeon Richard Berlin Jr., MD, because the center is licensed as a not-for-profit corporation and cannot engage in medical practice. The trial court had ruled that according to the Medical Practice Act, only individuals licensed to practice medicine may practice.

Although it is impossible to tell how the appeals court will rule, ISMS General Counsel Saul Morse said there was no indication that the justices opposed Dr. Berlin's position. One justice, in fact, "was particularly aggressive in questioning Sarah Bush Lincoln Health Center's attorneys and clearly pressed the point that changes with respect to the corporate practice of medicine are best left to the legislature rather than the courts. It seemed that [he] was pushing Sarah Bush Lincoln to give clearer and/or better reasons to overturn the trial court's decision."

Attempts by Sarah Bush Lincoln's

lawyers to equate physicians with nurses were challenged. The attorneys argued that physicians should be able to be employed just as nurses are, and one justice "suggested to them [that] an entirely different statutory scheme existed for nurses than existed for physicians, together with a different history of their relationship," Morse said.

The case stemmed from a situation that dates back to February 1994, when Dr. Berlin resigned from Sarah Bush Lincoln and began working at the Carle Clinic Association's Mattoon-Charleston branch, one mile from the hospital. In December 1992 he had signed a five-year employment agreement with Sarah Bush Lincoln that prohibited him from affiliating with "any person, firm or corporation engaged in competition with [the] hospital in providing health care services within a 50-mile radius" during the agreement's term and two years thereafter, according to Dr. Berlin's attorney, Cam Dobbins of Dobbins, Fraker, Tenant, Joy and Pearlstein in Champaign.

The health center filed suit to enjoin Dr. Berlin from practicing at Carle. He ultimately left Carle to establish a private practice but sued the hospital, seeking a declaratory judgment that the contract's

DIETICIAN JOANNA SCHIFERL (left) explains how to read a food label at a March 27 tour of Jewel Foods in Chicago. The tour was part of the Cart-Smart program launched by the American Heart Association of Metropolitan Chicago to help groups shop for heart-healthy groceries.



restrictive covenant was unenforceable. Also at issue was the contract's fee-splitting arrangement, which said the hospital would set all fees and have the exclusive right to bill for Dr. Berlin's services, Morse said.

ISMS, the AMA and five county medical societies filed an amicus brief in support of Dr. Berlin last fall. "This case deals with the question of whether corporations can practice medicine and whether hospitals and other corporations can employ physicians," Morse said in explaining why ISMS sought ami-

cus curiae status. "ISMS' policy always has been that physicians need that independence to be able to make medical judgments without the fear of losing their jobs because of decisions made regarding patient care."

The hospital has argued that the ruling may prohibit hospitals throughout the state from providing a full range of patient services, according to Sarah Bush Lincoln's lead attorney, Michael Duffy. "To maintain its accreditation, [my client] must offer comprehensive services," he said.

ISMS and KePRO to protest PRO contract decision

[CHICAGO] ISMS and KePRO, a wholly owned affiliate of the Pennsylvania Medical Society, will protest the mid-March decision by the U.S. Health Care Financing Administration to award the contract for the Illinois Medicare Peer Review Organization to the Iowa Foundation for Medical Care, according to Ronald G. Welch, MD, chairman of the ISMS Board of Trustees. ISMS and KePRO submitted a joint bid for the PRO contract last September.

"HCFA held a debriefing session with ISMS and KePRO, and based on the information gained, a decision was made to file a protest," Dr. Welch wrote in a letter to the ISMS Board of Trustees. The protest will be filed with the General Accounting Office.

HCFA rejected the ISMS-KePRO proposal due to technical details, Dr. Welch noted. The ISMS-KePRO bid, however, was some \$600,000 less than the IFMC bid. "If [the protest is] successful, HCFA could be required to re-evaluate the current IFMC and ISMS-KePRO proposals or HCFA could require another round of proposals to be submitted for evaluation," Dr. Welch wrote.

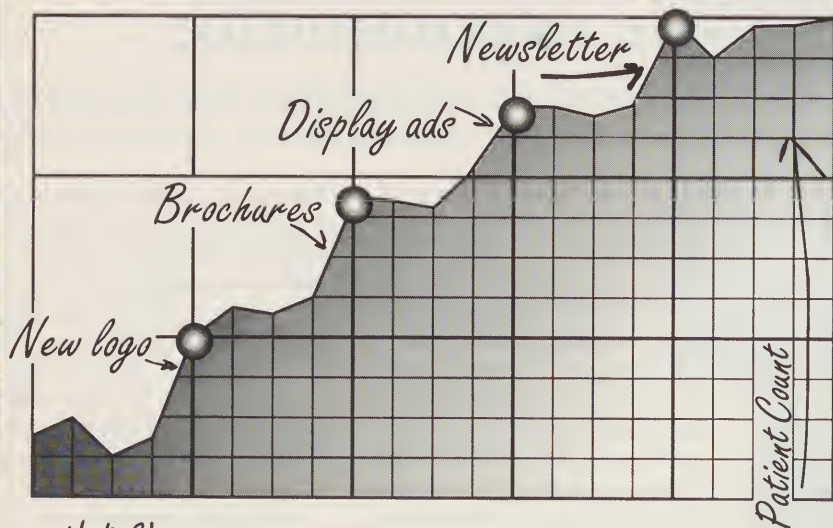
ISMS partnered with KePRO because the company was willing to offer a greater level of involvement than other PROs, including IFMC, according to John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. KePRO, for example, was favorable to a possible joint venture that would have given the Society direct input into policy, as well as the possibility for a future financial partnership, he said. IFMC offered ISMS only the opportunity to nominate one representative to its Provider Quality Improvement Committee, which would oversee all quality improvement efforts in Illinois, according to Dr. Welch's letter.

"The ISMS-KePRO collaboration has

been a valuable and productive endeavor for ISMS in that we learned a great deal about how PROs should and do operate," Dr. Welch wrote. "ISMS looks forward to continuing our relationship with KePRO. ISMS owes great appreciation to KePRO for its willingness and efforts to work with us as true partners and the investment it made in Illinois toward gaining the contract."

The protest process likely will take at least 30 to 60 days, Dr. Welch said. Illinois Medicine will report on the GAO's decision.

Patient Count



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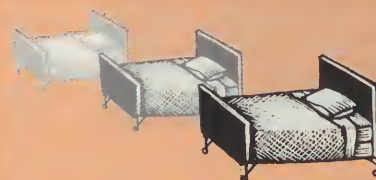
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Houston	-33.6
Detroit	-32.6
Dallas	-31.3
Chicago	-30.0
Los Angeles	-14.8

Source: The Sachs Group, Evanston, Ill., 1995

Lawmakers act on public health bills

LEGISLATION: Issues include public education, organ transplants, lead screening and hand-washing notices in public restrooms.

BY MARY NOLAN

[SPRINGFIELD] With the spring legislative session well under way, Illinois lawmakers have acted on several public health bills, including the following:

PUBLIC INFORMATION ABOUT SARCOIDOSIS

After Rep. Mary Flowers (D-Chicago) heard from a constituent who suffered from sarcoidosis about the lack of information on the disease, she tried unsuccessfully to learn about it, Flowers said. The cause of sarcoidosis is unknown, and it is often misdiagnosed as such illnesses as congestive heart failure, cirrhosis or obstructive pulmonary disease, Flowers added. "It is not a curable disease; it is a treatable disease. But one must know what one is treating first, and unfortunately a lot of people have died because of the misdiagnosis of the disease."

Flowers' research led her to sponsor H.B. 2564, which would require the Illinois Department of Public Health to make information on the symptoms and treatments of sarcoidosis available to the public. The House passed the bill Feb. 28, and it is now awaiting action by the Senate Rules Committee. ISMS supports the measure.

EXTENSION OF ORGAN TRANSPLANT TASK FORCE

A statewide task force on organ transplantation begun in 1995 would be extended for three more years under H.B. 2617, a bill passed by the House Health Care Committee on Feb. 28.

The measure would expand the task force by adding members who have experience in the field, including at least two physicians. It would also require a written report to be filed by Jan. 1, 1999.

"In the short time that the task force has been in existence, it has been a real learning experience for me," said Rep. David Wirsing (R-DeKalb), bill sponsor and task force member. "[Organ transplantation] is an area in health care that is unexplored, and for that reason, I think the task force needs to continue with its work." Obstacles in the area include high costs and the fact that insurance companies will usually pay for anti-rejection medication for no more than two years, he said. "The cost right now is \$2,000 a month, [and] it is almost impossible for patients to pay for their medication by themselves."

Wirsing said the task force must address the cost issue, the way in which organs are harvested and the criteria by which individuals are prioritized as recipients.

SCREENING CHILDREN FOR BLOOD LEAD LEVELS

Under H.B. 2800, if physicians and other health care providers believed children were at high risk for elevated blood lead levels, they could screen them in conjunction with school health examinations. The measure would target children who are at least 6 years old. Current law

focuses on newborns and children under the age of 6, said sponsor Rep. Monique Davis (D-Chicago). The House Health Care Committee passed the bill Feb. 20. "This [bill] is not meant [to require] the state or the education system to spend any additional money but [rather] to use valuable resources in teaching children about lead poisoning," Davis said.

Physicians can currently screen for blood lead levels with or without a school exam.

HAND-WASHING NOTICES IN RESTROOMS

H.B. 2828, sponsored by Rep. Edgar Lopez (D-Chicago), would have required

business owners to display a sign in restrooms encouraging hand-washing to prevent the spread of disease. The measure failed to emerge from the House Consumer Protection Committee.

The bill would have required IDPH to establish rules regarding the size, placement and number of signs in each facility. Business owners would have been fined \$100 for each missing sign, with repeat violations subject to court action.

The bill was in line with the position of ISMS' House of Delegates to initiate, encourage and support legislation requiring signs in public restrooms to help prevent the spread of disease. ■



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REPORT

for Illinois Physicians

MEDICARE

PAYMENT FOR EVALUATION AND MANAGEMENT (E/M) SERVICES DURING THE POST-OPERATIVE PERIOD USING THE -24 MODIFIER

Payment for surgical services commonly includes payment for the procedure and the care of the patient immediately preceding the procedure and during the post-operative period, which may be 0, 10, or 90 days. This payment methodology is called the global surgical package. E/M services rendered to the patient by the surgeon in the post-operative period are included in the global surgery package unless the reason for the visit is unrelated to the surgical procedure.

For E/M visits during the post-operative period, the -24 modifier needs to be added to the appropriate level of E/M service on the claim form in order for the service to be eligible for payment. These services must be sufficiently documented to establish that the visit was unrelated to the surgery. An ICD-9 diagnosis code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

Other circumstances which allow payment in the postoperative period include immunosuppressant therapy furnished by the transplant surgeon, chemotherapy, or critical care for a burn or trauma patient. Also, if the service occurs during a subsequent hospitalization and the diagnosis supports the fact that it is unrelated to the original surgery, the service is separately payable.

Treatment of the underlying condition is also sufficient documentation that the service is not directly related to the post-operative care of a surgery. For example, a diagnosis of coronary artery disease is an underlying condition which may require care unrelated to the surgery during the post-operative period of a pacemaker implant. Therefore, a claim for an E/M service billed with a -24 modifier and an ICD-9 diagnosis code for coronary artery disease should be payable within the post-surgical period of a pacemaker implant.

Claims submitted without a diagnosis which indicates the service is unrelated to the surgery will be denied.

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EDITORIAL

Matching business support with clinical expertise

As usual, Doctors' Day came on March 30 – but without much hoopla this year. Maybe there was just too much bad news competing for space. Physician burnout, for example, was the subject of an Associated Press story about the Conference on Physician Health, sponsored by the American and Canadian medical associations. Commenting on the health care marketplace, the Wall Street Journal reported, "In a bid to regain lost influence and income by joining forces with corporations, physicians are entrusting their futures to emerging companies in an industry buffeted by price pressures and ownership changes."

Yes, there are challenges for physicians, but there are plenty of resources, too. The feature story in this issue of Illinois Medicine discusses what physicians need to do to lead managed care organizations and how the Illinois Medical Physician Services Organization, developed by ISMS, will help meet those needs. A story in the "ISMIE Update" section explores how gatekeepers can remain patient advocates and minimize their liability in managed care settings. One way is by following the accepted standard of care for their patients regardless of any financial considerations, attorneys said. Future coverage will focus on the U.S. Health Care Financing Administration's new requirement that if managed care

plans put physicians at substantial financial risk for referral services, they must limit the doctors' financial losses.

ISMS also developed the Managed Care Patient Rights Act – a bill that would prohibit managed care entities from imposing gag rules on Illinois physicians. And the AMA has been instrumental in developing H.R. 2976, federal legislation that would do the same thing. Some HMOs are even dropping the clauses on their own. In early February, U.S. Healthcare Inc., a large operator of HMOs based in Pennsylvania, announced it was doing just that, according to AP.

There are also success stories that show what can happen when physicians have resources and opportunity. In a study of nine physician organizations nationwide sponsored by the AMA and two state medical societies, the primary element for success was found to be "a core of dedicated, clinically respected physician leaders who are developing proactive market-focused POs."

The Illinois Medical PSO will help physicians become more proactive and market focused. And the AMA and Northwestern's Kellogg Graduate School of Management recently teamed up to offer a curriculum in business plans.

Times may be tough, but physicians can get the support they need to match their business capabilities with their clinical expertise. ■

PRESIDENT'S LETTER

Fascinating things learned this year

Raymond E. Hoffmann, MD



I am convinced that the only way 18,000 physicians can make a decision on any one topic is through the democratic process.

The year is winding down. There are only a few more President's Tour stops. There are only a few more speeches to give. And after this one, there's only one more letter to write. While my time as president is ending, the major event of the year for the Illinois State Medical Society is upon us. The House of Delegates will meet in only a few days. Ever since I was the vice speaker and the speaker of ISMS' House of Delegates, I have been fascinated with how democracy works.

I enjoy knowing how things in general work. When I was a child, I took apart old clocks, vacuum sweepers, motors and everything else. I was even able to put most of them back together again. Each time, I was fascinated by what made the thing go. Now I do the same with the human body, and I still want to know what makes it go.

It has been the same with group decision-making. I am convinced that the only way 18,000 physicians can make a decision on any one topic is through the democratic process. The delegates understand how important the Annual Meeting is. For those of you who have never attended one of those meetings, I would encourage you to become a delegate or alternate. Your time will be well-spent. This is where you – the members of ISMS – decide the future of our organization and really the future of the practice of medicine in Illinois. You would be captivated as I have been.

This year I have also been fascinated by the varied medical practice environments I've seen in Illinois. This state is large and geographically diverse. But I think the practice climates outdo even the geography. There are solo physicians providing good care miles from hospitals and colleges. There are large, well-integrated groups of physicians with the latest in high-tech equipment for even the smallest of humans. And there seems to be everything in between.

I have noticed that so many physicians are willing to come out to dinner and talk with me. This is especially true in the smaller communities. Perhaps because they are geographically more distant from ISMS, they especially want to hear what is going on. This year I will have spoken to more than 2,000 physicians – a lot more than I ever thought possible. Fascinating.

Another thing that has impressed me is the congeniality of the physicians I've met. The many pressures in medicine today could divide us. However, there always seems to be mutual respect and admiration. It doesn't matter if physicians are in large clinics, practice independently or were trained in the United States or elsewhere. They all get along well. I think that is because doctors deal honorably with their patients and colleagues, expecting the truth from all.

All the physicians I've talked with want the best for their patients. They want to be able to make the necessary decisions. They have personal pride in their professional accomplishments.

In the past you've heard me say that being the speaker in the House was the most fun and challenging job I had had. Well, as the House approaches, I kind of wish I were back in my old job. I know our new speaker will do an excellent job, but it was fun to deal with the delegates and democracy.

As the year does come to a close, I know that our House of Delegates will carefully consider each resolution and each candidate for elected positions. I know delegates will do this with the congeniality and honesty we've come to expect from our colleagues. When I leave medicine, I want to leave the best of our profession behind for future generations. To do that we must decide issues in a democratic way and help our elected leaders steer us into the future.

Fascinating. ■

GUEST EDITORIAL

Never too young to be on the wrong end of a lawsuit

By Mike Royko

Reprinted by permission: Tribune Media Services

Some time back, I wrote about an 8-year-old Little League player who was sued for a hefty sum because he made a throw that conked a woman who was watching from a blanket on the grass. The case was interesting because the lawsuit was left on the boy's front porch, where he found and read it and almost went into shock.

Which wasn't surprising. Most 8-year-olds might twitch at reading a legal document that accuses them of causing pain, misery and suffering, as well as a husband's lack of consortium, and demanding what would amount to a lifetime of weekly allowance.

To bring the case up to date, a judge this week tossed the suit. That means the kid is off the hook, although his parents could still be sued, so I'll keep track of that. But when I wrote that column, I said that the boy was the youngest personal injury defendant I had ever heard of. Which just shows how naive I am in underestimating the initiative of modern victims and their eager lawyers. I recently heard from Mackie Schaars, of Carrollton, Texas, who wrote:

"You said that boy was the youngest defendant you have heard of. Well, have I got one for you.

"My son Connor, age 6, is named in a lawsuit, along with my husband and me. It was filed by our former baby-sitter for personal injuries sustained when Connor allegedly hit her when he was 4 years old.

"The sitter says he gave her a crushed larynx and other injuries and that she can no longer work, attend school or lead a normal life. She is suing us for \$2 million. Yes, you read that right. Two million dollars."

In a phone interview, Mrs. Schaars provided some details. "She was baby-sitting on Saturday night, but she didn't tell me about it until two days later.

"She said: 'I want to tell you why I have a raspy voice. Connor hit me in the throat, and the doctor thought I had lacerated vocal cords. But then he said my larynx was crushed.'

"I asked her how it happened, and she said she was squatting down in the kitchen talking to my other son, who was 6 at the time, when Connor charged up and hit her in the throat with his arm.

"So I talked to my sons about it. I asked them if they hit her. They said yes, but they couldn't remember why. And they said she told them, 'Be careful, that could really hurt someone if you hit them in the throat.'

"This happened in April 1994, and I got a letter in June saying they needed our insurance papers immediately or they would file suit.

"I notified our insurance company, and they offered \$1,000. That's what the insurance company offers if an accident happens on your property and you aren't negligent."

But the lawsuit was filed.

"During her deposition," Mrs. Schaars said, "she couldn't say why she needed \$2 million. She said it was for lost wages, but she had never filed an income-tax return. She did some detailing on cars for her father, but she mostly baby-sat and lived at home. Actually, she was an excellent sitter. She would play with the kids, or just sit and watch TV."

But what about Connor? Is he a large brute of a child, given to delivering potentially lethal blows or kicks, a la Mutant Ninja Turtles or Power Rangers?

"No," his mother says, "he's ordinary in size and strength. And one of his teachers says he's one of the sweetest children she ever worked with." The family's lawyer says that the suit asks for \$1 million for the pain and suffering the baby-sitter has already experienced. And the other \$1 million is for the pain and suffering she will experience in the future. Darn, there is so much misery in the world. The lawyer says that he believes Connor delivered the allegedly crushing blow because he wanted to play checkers, but the sitter told him to wait because she was busy trying to get his older brother to eat. So it could be a classic case of sibling rivalry rearing its ugly head.

Mrs. Schaars says she doesn't know how much pain and suffering her former sitter is currently enduring because she is now living in another community. "Maybe she doesn't want to be seen around town talking normally because that might indicate that her pain and suffering has subsided."

The case comes to trial next month, so we will see how much the family has to pay for little Connor's wicked forearm chop.

This case reminds me of something

Quotables

"The individual physician is out there, and he's not going to go away."

— **Charlotte Sibley**, pharmaceutical executive, on the assumption that managed care would control physicians' prescription pads, Medical Marketing & Media

"If you have a very severely restricted formulary, you may be restricting the care a patient gets."

— **Pam Kushner, MD**, a family physician, on a study that showed that patients in HMOs with restricted formularies were more likely to be ill longer and require more prescription drugs, Chicago Tribune

"The realities of managed care require us to seek from legislators safeguards for patients. Neither doctor nor lawmaker can abdicate these responsibilities to organizations whose motives are primarily financial."

— **Dickerman Hollister Jr., MD**, president of the Connecticut State Medical Society, on postdelivery insurance coverage for mothers and newborns, Connecticut Medicine

"The reason for a lot of the new interest in Chicago is that you can achieve some of the performance goals the state is looking for and do it profitably."

— **Edward D. Hutt, MD**, vice president and medical director of Milwaukee-based Managed Health Services, on why more HMOs are targeting Medicaid patients in Illinois, Crain's Chicago Business

"Physicians know how much of that profit is reasonable to drop to the bottom line before you truly start to impair care. I'm not sure that Wall Street does."

— **Steven Scott, MD**, president and CEO of a practice management company in Florida, on the conflict between pressure for earnings and quality of patient care, Wall Street Journal

"Maybe it's a sign — and this is coming from a lawyer — of how people are starting to rely too much on the courts to solve problems that just don't belong there."

— **Howard Spelcher**, attorney for a 3-year-old boy who was put under a court restraining order after kicking a little girl on the playground, Chicago Sun-Times

that happened when I was about 17 and was sitting with two of my little nephews. One of them snuck up on me and plunged a ballpoint pen into my forearm, causing me considerable pain and suffering.

Had I been quick-witted, I would have gone to Casimir, the neighborhood lawyer, and sued little Gus, my sister and brother-in-law for a million or two. I

know blood is thicker than water, but a million bucks can buy a lot of plasma.

Instead, I took the pen and jabbed little Gus in his arm, causing him a bit of pain and suffering, as well as wailing and howling. As a result, Casimir the lawyer lost a client. But little Gus grew up to be a respectable citizen. And to this day he has never stabbed anyone in the arm or elsewhere.

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ISMIE Update

Watch for coverage
of how to develop
patient brochures

Gatekeepers assume new risks with new responsibilities

Attorneys advise physicians to practice within their area of expertise, document referrals and explain all options to patients. BY KATHLEEN FURORE

Physicians in gatekeeper positions in managed care entities accept certain responsibilities, and along with them come additional risks, according to attorneys who deal with managed care issues.

"This increased risk is especially great for physicians who are new to managed care organizations and who are unfamiliar with the potential patient care pitfalls imperiling the gatekeeper-specialist-HMO network," said Michael Wagner of the Chicago law firm Baker & McKenzie. "Plaintiffs' attorneys are increasingly on the lookout for communications breakdowns, bureaucratic snafus and feeble follow-up procedures that might support their clients' liability claims against physicians."

"Are they accepting more risk? Absolutely," said Pat Foltz of the Chicago law firm Lord, Bissell and Brook. One problem is that managed care contracts can burden a doctor charged with overseeing a patient's care by limiting the number of tests, consultations and referrals the plan will approve, she explained. "But even though there are limits, the standard of care remains the same, and the physician is responsible even if the managed care organization's recommendations are not consistent with that standard of care." Adding to the dilemma is the fact that current ERISA law says managed care organizations cannot be sued for malpractice. Consequently, the risk of liability falls

back on the gatekeeper physician, Foltz said.

The type and scope of medical problems gatekeepers must manage also increase their liability, the attorneys said. "Sometimes the problem is that gatekeepers are asked to perform duties beyond their areas of expertise," Foltz said. "The classic example I hear is that managed care organizations are telling family physicians they should perform procedures even though they were not trained to do them or were



Wagner

trained but haven't done them for a long time. Traditionally, patients were referred to a gastroenterologist."

Conversely, some physicians may be specialized in areas that don't help them perform the gatekeeper role, Foltz said. "Some specialists are taking on primary care functions. A cardiologist, for example, might be considered a managed care patient's primary care doctor, even though [the specialist] is not used to handling many areas a family physician typically would handle."

The responsibility for making referrals to specialists and following up on them also increases gatekeepers' liability, the attorneys said. For example, a physician might hesitate to refer patients who are "close to the line," Wagner said. "Say a patient meets two or three of the four criteria needed to justify referral—that's a close call. So the doctor, who in his or her heart of hearts is a true patient advocate, says, 'I think I know how to deal

with this, even though I'm not quite as confident as a specialist would be.' Trying to do more is one way [gatekeepers] increase [their] liability exposure."

The potential to lose track of patients who are referred to specialists is another problem area for gatekeepers, Wagner noted. He cited the case of a primary care doctor who referred a patient to a neurologist because of persistent and severe headaches. "The neurologist sent a form requesting an MRI back to the gatekeeper, who was supposed to see that the patient got the MRI as soon as possible. But the primary care doctor didn't keep good track of referrals made back to him." Even after the patient's wife called the gatekeeper's practice regarding the recommended MRI, nothing was scheduled. The patient died of a ruptured aneurysm.

"The doctor let it fall

between the cracks because he had no procedures in place to take care of follow-up," Wagner said. "It ended up being a very serious exposure case for the primary care doctor and the HMO, which resulted in a substantial settlement." The neurologist, however, was not found liable, because he had documented his recommendations and his follow-up with the primary care doctor, he noted. "This is the type of situation where not tracking a patient, if you're the primary care physician, can be costly in terms of human injury."

Although the managed care referral process can create risks, Wagner said he "doesn't want to suggest that primary care physicians are creating huge liability exposure [simply] by referring patients [to specialists]." However, he stressed that gatekeepers should clearly document all activities and communication regarding patient referrals. "I have a slide that says, 'To treat or not to treat may or may not be the question. But to

document, that is the obligation.'"

Adhering to the accepted standard of care is essential, the attorneys said. "Gatekeepers should be practicing the same way they always have practiced absent a managed care organization contract," Foltz said. "Even though it may impose some financial burdens, they have to look at the standard of care because that is what they'll be held to if they're sued. It's the only way to defend a malpractice case, because they will be questioned regarding financial incentives."

"The standard of care in Illinois says that doctors must use the same skill and care a reasonably well-qualified primary care doctor or specialist would use under the same circumstances," Wagner said.

Physicians should also explain all options to patients

(Continued on page 7)

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MALPRACTICE ROUNDUP

Undetected amniotic leak results in \$9 million award

A Pennsylvania jury awarded \$9 million to a woman whose baby was born two months early and with cerebral palsy after her physician failed to detect leaking amniotic fluid, according to the February 1996 issue of Medical Malpractice Law & Strategy.

In *Lahav vs. Main Line Ob/Gyn Associates*, the plaintiff said she noticed a leakage of amniotic fluid for five days after undergoing amniocentesis. Although she visited her obstetrician's office several times, no tests were performed, the story said. The problem persisted, and an ultrasound was finally ordered. It showed little or no amniotic fluid remained, so the physician ordered bed rest for the patient. After developing an infection, the patient experienced premature labor and gave birth to the disabled baby. The patient then sued the obstetrician and his medical group, alleging that the risk of complications would have been less had the leak been detected earlier, the summary noted.

The defense argued that all necessary tests had been performed and were negative. The jury, however, ruled in favor of the plaintiff, the story said. ■

Jury rejects claims of Motrin-induced lupus

A New York jury rejected a medical malpractice lawsuit against Columbia Presbyterian Hospital and three physicians Feb. 6, according to a story in the March 11 edition of the *National Law Journal*. In *Firestone vs. Jaffe*, the plaintiff claimed that treatment with Motrin had induced lupus and that he had been misdiagnosed with real lupus, which must be treated with higher doses of corticosteroids than the drug-induced form. The plaintiff alleged that the high doses caused a psychotic reaction, causing him to try to kill his wife and resulting in his involuntary commitment and post-traumatic stress disorder.

The defendants denied Motrin had caused the patient's lupus and said high doses of steroids were necessary to treat his condition.

The plaintiff sought \$8 million, but the jury returned a unanimous verdict for the defense, the article said. ■

Hospital's exclusive contract 'extinguished' physician's clinical privileges

CONTRACTS: Appellate court finds doctor was entitled to notice and hearing procedures.

BY KATHLEEN FURORÉ

[CHICAGO] The First District Illinois Appellate Court has ruled that a hospital adversely reduced a cardiovascular surgeon's clinical privileges when it entered into an exclusive contract with another surgeon to perform open heart surgery, according to a report in the January 1996 issue of Health Law News. The physician, who sought injunctive relief and damages for breach of contract and tortious interference, was entitled to the notice and hearing procedures described in the hospital's bylaws, the story said.

The plaintiff had belonged to a cardiovascular group that had an exclusive contract with the hospital to perform open heart surgery. After that group dissolved in early 1992 and started a new corporation without the plaintiff, the group's physicians and the plaintiff were allowed to perform open heart surgery at the hospital, the story said.

Later that year, the hospital signed the exclusive contract with a doctor in the new group, saying that only he and his employees could perform open heart surgery at the hospital. One month before entering into the new contract, the hospital discovered that the plaintiff's mortality rate had increased and that some of his assistants were not cardiovascular surgeons, according to the story.

The plaintiff claimed when the hospital contracted with the other physician, it failed to follow the notice and hearing procedures required by its bylaws and

terminated his clinical privileges. Although the trial court said the physician's staff privileges had not been revoked and there was "no impropriety" in the hospital's actions, the appeals court reversed and remanded that decision. On appeal, the hospital argued that its bylaws entitled it to enter into an exclusive contract and that they did not require the hospital to hold

a hearing when entering into such contracts. However, the appeals court determined that "the plaintiff's clinical privileges had been extinguished by the exclusive contract. The hospital's bylaws specifically address actions that suspend, limit or reduce clinical privileges."

"Counsel to both hospitals and physicians should heed this case as a reminder

to familiarize themselves with the provisions of the medical staff bylaws to which their clients will be subject in situations involving issues of physician credentialing and medical staff membership," the article concluded. That is especially important in a managed care environment that "may significantly impact physicians whose employment or independent contracts are terminated, not renewed, or otherwise negatively affected by hospitals, or whose clinical privileges become limited or revoked (effectively or actually) as a result of new relationships entered into by hospitals," the story said. ■

Gatekeepers assume

(Continued from page 6)

"whether or not those options are recommended by the managed care organization," Foltz said. "If a patient requires something that's not recommended, the doctor should act as that patient's advocate within the managed care organization's appellate process to appeal denials of payment decisions. That can be an effective way of getting the plan to cover [the treatment]. That approach protects the physician and the patient."

A case that underscores the importance of physicians going to bat for patients is Wickline vs. State of California, Wagner said. The doctor in Wickline requested and the managed care plan approved a 10-day postoperative stay. But when the patient developed complications and the doctor requested an eight-day extension, the plan would approve only a four-day extension. The patient was discharged, developed an emergency condition and had to have her leg amputated. In the resulting lawsuit, the court ruled that the physician — not the managed care plan — was responsible because he had not objected to the shortened stay, Wagner said.

"The moral of this story is that primary care doctors who don't agree with a managed care organization's decision on appropriate lengths of stay need to not be content with the decision," Wagner said. "They have an obligation to take it to the next level, to seek approval, to make the appropriate records and hopefully to convince the decision-maker of the need for a longer stay." ■



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Illinois Medical PS follow the golden r

'Those who have

BY KATH

Many doctors have at least thought about the possibility of getting involved in a physician-directed managed care entity that accepts risk-based contracts. To explore the options and benefits of such organizations, Illinois Medicine interviewed John Ray, president of the Clearwater Group Ltd., a California-based consulting firm. Ray has been instrumental in helping ISMS develop the Illinois Medical Physician Services Organization, which will offer business support for physician-driven managed care organizations. A resolution affirming the implementation of the PSO will be considered by delegates at the Annual Meeting this month.

Why should physicians consider forming organizations that will accept risk and manage contracts?

Health care as a business is changing, and the physician-patient relationship and clinical autonomy are at stake. The people who pay for care are determined to control their health care costs, and health care is changing from a debt-financed to an equity-financed business. The availability of equity capital is fueling massive consolidations of hospitals and insurance companies. With that consolidation comes control over the flow of patients, the money associated with those patients, the information associated with the care of those patients and clinical decision-making.

There are two principles doctors need to understand. One is that profit is the reward for risk, and without taking risk they have no claim over profit or control over decision-making. The other is the golden rule: The one who has the gold makes the rules.

How can physicians position themselves to make the rules?

They have to organize themselves into physician-directed businesses and clinical enterprises that can secure and successfully manage capitated contracts. Or in markets where there is no capitation and where discounted fee-for-service prevails, they have to – to the extent possible – get a greater degree of control.

At one time insurance companies were seeking to capitate. Now they realize they can make more [profit] with discounted fee-for-service. But under a discounted fee-for-service payment system with external controls over clinical decisions such as referrals to specialists and approval for admissions – things that have substantive economic implications – physicians probably lose both economic and clinical control.

Why is that?

Fees per unit of service will decrease, and the number of units of service will decrease. And who keeps the profit? The company taking the risk – the insurance company. Since they have the gold, they make the rules.

How can physicians avoid losing control in discounted fee-for-service situations?

It's not easy. They have to structure risk-sharing arrangements with insurers. For example, [a risk-shar-

ing arrangement] could be structured around hospital costs so the physicians would be accepting partial risk. The insurer would set a budget target, and if money was spent in excess of that budget, the physicians would be partly accountable. But if there were surpluses, the physicians would get a financial reward. You could do that with pharmacy [services], too.

To get involved in the kinds of risk-sharing arrangements you describe, what is the minimum physicians must do?

It depends on the extent of the risks. But [their success] will hinge on certain things. They have to have physicians who are committed to a common enterprise. It can be an IPA, the physician component of a PHO or a group practice. The common thread is that the organization is physician driven and has good leadership and members' commitment and loyalty.



Matt Ferguson

They have to have good management people in place who are supportive of physician-driven managed care and who understand the business functions needed to make it work for doctors. And they need information that is accurate, timely and clinically meaningful, with a single database owned by the doctors.

What should these organizations do – or contract to do – in order to succeed?

Once physicians take capitation or enter a risk-sharing contract, they in a sense become an insurance business and need to adopt the management techniques of an insurer. But it's more complicated than that because their success over the long term depends on the success of patient care. So they need a company that can grow, manage risk and use an evidence-based approach to managing the process of care.

They have to be able to manage the risk of statistical variance – the risk that bad things happen. Since

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make the rules.'

URE



risk decreases with size, the major way to manage that is to promote and grow the practice. So there has to be a marketing and sales function. You'll also get more cash flow, so you can do more, and there will be more cash to give the physicians' practices, which generates loyalty.

They also have to manage the risk of selection — that patients signing up may have health care needs in excess of that assumed in the calculated payment rate. They have to manage cash flow risk. They have to make sure bills and claims are paid accurately and in a timely fashion. They've got to keep track of where they are financially, negotiate good contracts so payment rates are high and reflect the patient population that will be enrolled, and think about how to use clinical evidence to explain and reduce unexplained variances in health care outcomes among patients.

The Illinois Medical PSO will offer physicians management expertise to help them organize and structure the kind of physician-driven organizations they need to successfully manage risk-based contracts. These groups will need bylaws, a governance structure, a consensus-building structure. And through the PSO's consultation and development services, physicians will be able to structure completely new groups or refine already existing groups.

How would physicians use 'clinical evidence' to deal with varying outcomes?

The process of care is not about managing physicians' decisions in the exam room. It's a matter of [having in place] support systems to improve the ability to collectively reduce unexplained outcomes. You need decision support systems that aren't necessarily electronic — things like ready access to consultations with colleagues. It could be doctors working together to define optimal outcomes and processes. Other things these physician enterprises need are better

patient disposition options, better discharge planning and better access to step-down units. But these things must evolve over time.

What specifically will the Illinois Medical PSO help doctors do?

The PSO intends to put in place a sophisticated information management system so physicians can have access to their own databases for their own businesses. But it will share common hardware, software and 'liveware,' so they can achieve economies of scale and of personnel. In addition, some of the PSO's functions are expected to include claims and capitation processing, risk pool contracting, financial reporting, utilization reporting and assistance with billing, collections and office operations, which would help increase practice efficiency in discounted fee-for-service arrangements.

How can physicians determine what steps to take next?

They should ask themselves how, over the next five to 10 years, the organizational choices they're making now will help them improve the health care they give their patients and also how those choices will help them improve their ability to take care of their families. They have dual responsibilities, and it's not the insurer's job to worry about the doctor's livelihood.

Is forming risk-taking organizations the best way for physicians to accomplish those goals?

I don't think they have much choice. It's happening to them. I suppose they could completely avoid taking risk. But the trade-off is that they'll have no control, and the fees they get will decline over time. It goes back to the two principles I mentioned earlier: Profit is the reward for risk, and the one who has the gold makes the rules. ■



Federal program helps physicians refinance loans

TERMS: New program lets doctors lower the interest rate and extend repayment on their Health Education Assistance Loans. BY KATHLEEN FURORE

[ROCKVILLE, MD.] Physicians who took out a Health Education Assistance Loan to pay for medical school can now reduce the interest rate and lengthen the payback period on those loans through a federal refinancing program. Ten lenders nationwide currently offer the program, which enables doctors to consolidate all their HEALs into one new loan, said Michael Heningburg,

director of the Health Resources and Services Administration's Division of Student Assistance.

HEALs are often called last-resort loans because interest is set at prevailing commercial rates and begins accruing while borrowers are still in school, according to Heningburg. "The potential for long-term savings as a result of this initiative for physicians is dramatic," he

said. "We believe that once physicians become aware of the benefits of refinancing, they will choose that option."

Those benefits include lower interest rates for nearly all borrowers who assumed loans before 1992, slower accumulation of total interest, various payment options including graduated and income-contingent plans, the option to prepay without penalties and more time

to pay off the loan, which reduces monthly payments. There is no charge to participate in the refinancing program, according to information from HRSA.

Almost 3,000 Illinois physicians have borrowed through HEAL. But recent government figures show that fewer than 175 Illinois doctors have refinanced to date, HRSA said. "Some young physicians are coming out of medical school with \$100,000 or \$150,000 in loans," said ISMS President Raymond Hoffmann, MD. "I think anything that could help them pay back these loans in an orderly fashion would be a great help and would be greatly appreciated."

Physicians just starting out in their medical careers often need assistance in managing their finances, said AMA President Lonnie Bristow, MD. "HEAL refinancing is the kind of program that can really help, since it gives doctors a fresh start on their loans."

Increased cash flow through refinancing can also help physicians who are at risk of defaulting on their HEALs. That is especially important, since the federal government publishes the names of borrowers who have defaulted and withholds their Medicare and Medicaid reimbursements and federal income tax refunds, according to HRSA.

To receive the pamphlet "HEAL Refinancing: Is It Right for Me?" and a list of lenders that participate in the program, contact the ISMS office services division at (312) 782-1654 or (800) 782-ISMS, ext. 1181. ■

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Group develops directory to address child abuse

[CHICAGO] The Illinois Chapter of the American Academy of Pediatrics Committee on Child Abuse and Neglect is producing a directory of medical consultants for children who have been abused or neglected. The directory will be based on a survey of pediatricians and family physicians regarding their experience working with abused children. Those who did not have such experience were asked to name the physician to whom they referred these cases.

The group plans to distribute the directory this fall to Illinois pediatricians and family physicians as well as emergency department staff and other personnel who deal with abused children. ■

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Physicians lead

(Continued from page 1)

sign contracts with BAIPA, and we deliver the patients and cut the paychecks to the physician's practice or to the hospital if the physician's salary is paid by the hospital."

BAIPA has always accepted capitation and saw its first true managed care patient in January 1979, according to Carlson. The group currently has contracts with HMO Illinois and Maxicare, accepting capitated risk as participants in those health plans and handling about 13,000 covered lives through the two HMOs. Another 7,000 patients come through Community Medical Management Services, BAIPA's self-administered PPO, through which the group can contract directly with employers. "There isn't the risk [with the PPO] that there is with the HMO contracts, and it eliminates the expensive middleman — the insurance company," Carlson said. "The doctors are paid more, and the risk is less. It's a win-win situation for the payers and providers."

As a physician-run network, BAIPA relies on physicians for peer review, credentialing and other decisions that directly affect member doctors and their patients. More than 80 physicians are involved in a peer review capacity with BAIPA, and committees evaluate quality issues and practice patterns. A member-elected board of directors appoints all committees, including BAIPA's executive committee,

which functions as the organization's credentialing entity and makes credentialing recommendations to the board.

"We have removed physicians from the network if they're not cost-effective or if [their practices] are not compatible with managed care," Carlson said. "And we also haven't credentialed some physicians because they don't meet our NCQA [National Committee for Quality Assurance]-consistent standards. But quality, not just cost, drives our decisions. Every effort is made to help physicians identified as outliers improve their standards of practice."

"As a practicing physician, I want the least interference I can get or have to accept between me and my patient," Dr. Frederick said. "With BAIPA any interference is doctor to doctor. There's not some 800 number with a recording at the end."

As its 20-year track record attests, BAIPA has weathered the move to managed care successfully. The network now employs eight nurses who are involved in precertification, referral management, concurrent review and case management activities. It recently invested in a \$250,000 computer system. The group is also "loosely affiliated" with the Blackhawk Area Medical Association as part of a centralized credentialing program, Carlson said. BAMA gathers and verifies credentialing information for area hospitals and managed care entities that use the service, while BAIPA's executive committee decides which physicians should be credentialed. "The value of this is that

physicians have to respond to only one form. They don't have to complete a form for every entity with which they want to be affiliated."

THE GROUP HAS BEEN affected by the evolution of health care delivery, though. Increased fragmentation of physicians, for example, has trimmed BAIPA's membership, Carlson said. "Back in the old days our physician network was a lot larger. At the height there were 750 physicians — only a small exception [in the area] were not participating. In 1980 a large group formed its own HMO. And hospitals have been very aggressive in hiring primary care doctors. Now about 60 percent of [area] doctors participate, and physicians have

other driving loyalties to hospitals, PPOs."

Some physicians, however, are coming back to BAIPA, he said. "They're finding that a physician-run program basically [offers] a more friendly environment than [is found] in hospital- or insurance-run programs."

"I think our basic concepts will prevail," Dr. Frederick said. "As physicians become more disenchanted with for-profit organizations, PHOs, hospitals and corporate-owned [entities], they'll be more inclined to work with physician-owned organizations. It takes some sting out of this [new system of health care delivery] for physicians to work with physician-controlled and -owned groups." ■

Two rural ambulance services receive IDPH grants

[SPRINGFIELD] The Jersey-Calhoun and Johnson-Pope regional ambulance services each received \$50,000 in grants to improve care in their areas, according to John Lumpkin, MD, director of the Illinois Department of Public Health. The grants were awarded as part of the Illinois Rural Health Act enacted in 1989 by the Illinois General Assembly to improve services in medically underserved rural regions.

With the money, Jersey-Calhoun and Johnson-Pope can upgrade their ambulances, buy equipment and provide training for emergency medical technicians. Noting that some areas of Illinois lack

the funding to improve current services, Dr. Lumpkin said, "These kinds of upgrades will help save lives in the long run."

An ambulance service seeking a grant must cover two or more contiguous counties that form a designated health care shortage area, and each of the counties must have a population of 20,000 or fewer. The ambulance service also must have a regional board made up of at least three members from each county. Other criteria include the applicant's proposed use of the funds and its current operational budgets and projections for becoming self-sufficient. ■

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HIV counseling bills

(Continued from page 1)

mend that all counseling and written materials provided be appropriate based on the linguistic, cultural and educational background and age of individual patients. The guidelines also advise physicians to encourage uninfected pregnant women who continue their high-risk behaviors "to avoid further exposure to HIV and to be retested for HIV in the third trimester of pregnancy."

The Illinois Department of Public Health, which also opposed the legislation, developed similar guidelines that were first distributed to physicians in November 1991. "We support the concept and the idea that women should be counseled about HIV and offered testing," said IDPH spokesperson Tom Schafer. "But we believe a mechanism already is in place. Doctors generally are following our guidelines."

The cost of implementing a mandatory counseling program was also a factor, Schafer said. "It would have cost us between \$200,000 and \$400,000 to provide doctors with the written materials, videos and consent forms [the legislation required]. Doctors would have had to give us monthly reports, and we would have had to complete a quarterly report, which would have required additional staff. None of the bills provided any money, so we felt they were taking away from the scarce resources we have for AIDS."

One physician who thinks HIV coun-

seling for pregnant women should be legislated is Ellen Chadwick, MD, associate director of the Section of Pediatric and Maternal HIV Infection at Children's Memorial Hospital in Chicago. The hospital is the largest provider of HIV-related care for children in the Midwest and currently cares for more than 100 HIV-infected children, according to a hospital spokesperson.

In testimony before the Senate Public Health and Welfare Committee, Dr. Chadwick said: "We believe that this legislation will help maximize compliance among prenatal care providers to make HIV education and counseling available to all pregnant women. We know that physician compliance levels increased and many lives were saved once public health laws were passed requiring physicians to vaccinate children and to perform prenatal syphilis tests as a routine standard of care."

Evanston Ob/Gyn M. LeRoy Sprang, MD, however, disagreed: "I think practicing Ob/Gyns will voluntarily follow the CDC guidelines. It is not in the best interest of physicians or patients to mandate counseling. It is an unnecessary intrusion of government where it is not needed. It makes no better sense than mandating a cholesterol check. If something is good medical practice, physicians will encourage it."

Dr. Sprang said such discussions are a regular part of the physician-patient relationship. "If you're comfortable with a patient and say, 'We routinely discuss HIV because it is an important matter,' it

won't be a problem. We do other things — like check for gestational diabetes — as a routine, and patients don't question that. You don't need a law to back up what is reasonable and common sense."

Although the measures did not emerge from committee, Walsh said he was glad the hearings took place. "I think we can go from here and keep the discussion going. We saw that this bill might not be the way to go, but I think it is important

to address [HIV infection in pregnant women]. Dr. Chadwick said she has seen an increase in the number of kids born HIV-positive. And studies have shown that if you could start treating women with AZT while they're pregnant, the chances of the baby being born HIV-positive are greatly reduced. So even if it doesn't happen through this bill or some type of legislation, we have to make sure this information is getting to moms." ■

ISMS HOD

(Continued from page 1)

communities and to help "identify and explore opportunities for providing services to physicians and their organizations."

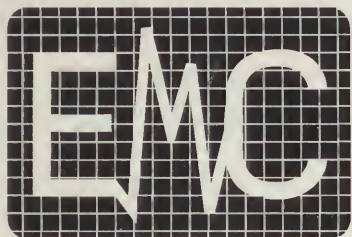
Managed care-related resolutions include one asking ISMS to support legislation requiring insurance companies, HMOs and managed care companies to file certain information for public review with the Illinois Department of Insurance. That information would include bonuses and other financial incentives that reduce insurance costs and, when not disclosed, could limit patients' ability to make informed choices about doctors, hospitals and health insurance plans. Another proposes that the Society create a mechanism by which insurers who do not finish the credentialing process and respond to applicants within six months of receiving a completed application would be reported to the Illinois Department of Insurance for disciplinary action. And a third directs ISMS to pursue "leg-

islative and/or legal action to prevent managed care programs from denying the participation of qualified physicians."

Regarding public health, delegates submitted proposals asking the Society to develop corrective changes to the rules and regulations of the Illinois Lead Poisoning Prevention Act, to work with the Illinois Department of Transportation to study the problem of railroad crossing safety, to urge the state legislature to lower the acceptable blood alcohol level for operating a motor vehicle, to advocate and encourage the development of legislation that would prevent billboard advertising of alcohol products and to ban smoking in all health care facilities and restaurants in Illinois.

Medicaid coverage for teens and workers' compensation are other topics of resolutions.

Illinois Medicine will provide detailed coverage of the House of Delegates' actions on these and other resolutions in upcoming issues. ■



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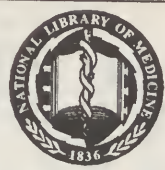
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Elmhurst Memorial
intends to
join Northwestern
Healthcare

PAGE 2

Ron Ackerman



NATIONAL DOCTORS' Day on March 30 became a time to celebrate free clinics when ISMS sponsored a daylong free-clinic workshop in Springfield. John M. Holland, MD, of Springfield, speaks on liability, insurance and quality assurance as part of the program. Also addressed were funding, recruitment, administration and pharmaceutical issues.

Health and Human Services issues
final rule on HMO incentives

PROTECTION: Managed care plans that put physicians at financial risk must limit those physicians' losses. BY KATHLEEN FUREORE

[WASHINGTON] Addressing concerns that managed care plans' financial incentives for physicians can affect the public's access to care, the Department of Health and Human Services on March 26 issued a rule that protects doctors and patients in Medicare and Medicaid managed care settings. Plans offering incentives that put providers at "substantial financial risk" for referral services must "provide adequate protection to limit financial losses," according to the regulation. In addition, they must conduct annual patient satisfaction surveys. The risk is considered substantial if more than 25 percent of a physician group's potential payment is at risk for services it does not provide, according to HHS.

Primary care physicians who practice in capitated systems,

for example, are liable for the costs of specialty care to which they refer their patients. That arrangement could be considered an incentive to minimize referrals, since the more referrals the physicians make, the lower the payments they retain, HHS said.

Under the new rule, physicians who meet the substantial risk criteria must receive protection from prepaid plans for 25 percent of the total potential payments or a fixed amount per patient. The number of patients the physicians serve will determine the amount, HHS said.

The rule also requires managed care organizations to disclose their physician incentive plans to the U.S. Health Care Financing Administration or to the state Medicaid agency, and on request to plan patients. In

addition, it prohibits plans from making payments to physicians specifically for limiting or reducing medically necessary services to an individual enrollee, HHS said.

"The final rule addresses some of the concerns of Congress and the public about the pressures and incentives HMOs create for physicians' care decisions," said Bruce Vladeck, HCFA administrator.

"I think this is a positive step that is in the best interest of patients' health," said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. "And it protects the physician who finds that a patient needs extensive care. This represents the kind of legislative efforts ISMS is undertaking in Springfield to provide adequate protection for patients." (Continued on page 10)

HIV-infected woman files suit
against Illinois blood bank

COMPLAINT: Plaintiff says she contracted the virus during surgery because of blood bank's negligence.

BY KATHLEEN FUREORE

[CHICAGO] A Lansing, Illinois, woman who contracted HIV during hip replacement surgery filed a medical malpractice suit March 29 in Cook County Circuit Court against Heartland Blood Centers of Aurora. The complaint alleges Heartland failed to properly test the blood it supplied to St. Margaret Mercy Hospital in Dyer, Indiana, where 75-year-old Florence Schieben underwent surgery in September 1994. The suit was originally filed in Indiana's Lake County Superior Court but was refiled after a March 22 ruling that the case should be tried in Illinois, based on Heartland's location.

Schieben, who is demanding a jury trial, seeks damages in excess of the \$50,000 jurisdictional limit set by the law division of the Circuit Court of Cook County, the complaint said. Her husband is also seeking judgment against Heartland for damages including loss of consortium.

"Defendant Heartland, by and through its agents and employees, was negligent, careless and otherwise breached its duty of care," the complaint

said. Among the allegations are that the blood center "negligently tested and failed to perform all necessary, recommended and required tests on" the blood given to Schieben.

Heartland's first ELISA HIV antibody screening test on the blood resulted in a reactive finding, according to the complaint, and a duplicate test was performed. The machine used in the second test interpreted the sample as nonreactive, and no one at Heartland "made any independent medical judgments or conclusions but instead relied solely upon the accuracy of the [machine's] interpretation of the results," the complaint said. Although the second test result was considered "borderline reactive" based on an insert from the test manufacturer, Heartland did no further testing. It labeled the blood negative for HIV without indicating the blood had been reactive to the first ELISA test, according to the complaint. In addition, the complaint alleged the blood center didn't have standard operating procedures that included quality control rules

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overhaul of state
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John McNulty

RACE FOR THE CURE, a series of nationwide 5K runs to raise money to fight breast cancer, kicks off March 26 at Quaker Tower in Chicago, where Nancy G. Brinker (center), a national crusader against breast cancer, greets attendees.

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Elmhurst Memorial intends to join Northwestern Healthcare

[ELMHURST] Elmhurst Memorial Health System, the parent company of Elmhurst Memorial Hospital, announced April 2 that it has signed a letter of intent to join Northwestern Healthcare. Elmhurst will become the ninth member of the Northwestern network, which is the leading integrated health care delivery system in the Chicagoland region, according to a joint news release. The two entities expect the affiliation to receive full approval and be finalized by July, according to a Northwestern Healthcare spokesperson.

"It is our intent to become affiliated

with this prestigious network of health care providers so that we can continue to provide the high-quality, compassionate health care that our community has come to expect from Elmhurst Memorial Hospital," said Leo Fronza, president and CEO of the Elmhurst Memorial Health System.

The DuPage County hospital has 435 licensed beds, a staff of more than 2,400 and a medical staff of about 550 physicians. It offers open heart surgery; a Level II trauma center; home health care, maternity, oncology and orthopedic services; and the new Magnuson Pavilion, which

provides cardiac catheterization, critical care, endoscopy, outpatient cancer care services and the largest single-room maternity center in the Chicago area. In 1995, the hospital and its subsidiaries reported net revenues of \$170 million. In addition, Elmhurst Memorial has managed care contracts with more than 40 major insurance companies and payers in the Chicago area, according to the news release.

"Elmhurst Memorial Hospital furthers Northwestern Healthcare's goal of linking strong, community-based health care institutions and their physicians into a comprehensive delivery system serving the Chicago region," said Bruce Spivey, MD, NH president.

Elmhurst Memorial will, however, retain its current governing board and management. Its medical staff will remain independent, and such system-level activities as marketing will be coordinated with other network members through representation on the NH board and committees, according to the news release.

Once the Elmhurst affiliation is complete, Northwestern Healthcare will include more than 5,300 physicians, operate 3,500 beds and admit more than 140,000 patients annually. Other members of NH are Children's Memorial Medical Center; Evanston Hospital Corporation, which includes Evanston and Glenbrook Hospitals; Highland Park Hospital; Ingalls Health System; Northwest Community Healthcare; Northwestern Memorial Hospital; Silver Cross Hospital and Swedish Covenant Hospital. ■

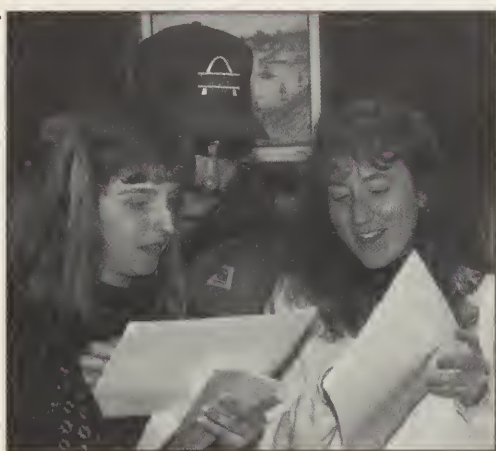
CMS to present managed care forum

The Chicago Medical Society will offer a managed care forum May 15 from 4:30 to 6:30 p.m. at the CMS offices at 515 N. Dearborn St. in Chicago. A panel of six physicians will discuss their perspectives on managed care. WBEZ-FM radio host Mara Tapp will moderate the forum, which is free and open to the public.

The panelists include Biswamay Ray, MD, CMS president; Arvind Goyal, MD, chairman of the Ad Hoc Committee on Managed Care; Quentin Young, MD, CMS member; Mervin Shalowitz, MD, vice president and medical director of United Healthcare of Illinois and professor of medicine at Rush Medical College; Gerald Silverstein, MD, senior vice president and chief medical officer of NYL-Care Health Plans of the Midwest Inc.; and Alan Rosenberg, MD, medical director of Aetna Health Plan of the Midwest.

For more information, contact Holly Sawtelle at (312) 670-2550, ext. 213. ■

Southern Illinois University



IT WAS A MATCH-DAY match on March 20 for April Bottrell of Blue Mound (left) and Christine Cornelius of Sherrard, classmates at the Southern Illinois University School of Medicine in Springfield. Both women will enter family practice residencies in July. SIU has one of the country's highest percentages of medical students to enter primary care fields.

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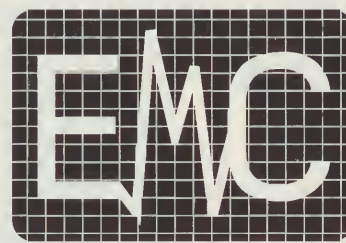
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Governor orders overhaul of state government

EXECUTIVE DECISION: One department will replace seven state agencies. BY KATHLEEN FURORE

[SPRINGFIELD] On March 29, Gov. Jim Edgar issued an executive order to streamline state government by establishing the Department of Human Services. The new department, scheduled to be created July 1, 1997, will deliver services currently provided by seven state agencies, according to a news release from Edgar's office.

"With this overhaul, we are targeting unnecessary bureaucracy, duplication, overlap and lack of coordination—all of which add to the cost of government and detract from our ability to help those who turn to us for help become as self-reliant and independent as possible," Edgar said in announcing the executive order. "The action I am taking builds on the progress we have made by taking a giant step forward to make delivery of services to the truly needy more effective and more efficient and to give prevention efforts the focus and support they merit."

Under the current structure, for example, separate agencies administer day care, employment and teen pregnancy programs. As a result, people have to deal with several agencies and may receive conflicting information from each agency, according to the release. "Services are splintered. The bureaucracy is too bulky. We can do much better,

and we will do much better [with the new department]," Edgar said.

A 15-member task force will work on the reorganization, which is scheduled to be phased in over the next two years. The executive order calls for the new department to replace the Department of Mental Health and Developmental Disabilities, the Department of Rehabilitation Services, the Department of Alcoholism and Substance Abuse and the Department

on Aging. Concurrently, other agencies will assume responsibility for several programs now provided by the Department of Children and Family Services. The Department of Public Aid's Youth Services Division, for example, will take over child care and youth services programs; the Department of Human Services will handle the adolescent psychiatric program; the Department of Corrections will take on delinquency prevention programs;

and the Department of Revenue will manage the pharmaceutical assistance program, the governor's office said.

On Jan. 1, 1998, the Department of Public Aid and the Department of Public Health are scheduled to become part of the Department of Human Services. At the same time, the new, freestanding Office of Health Regulation will become responsible for regulating health facilities including hospitals, nursing homes and laboratories. That task now falls to the Department of Public Health. Finally, the Department of Children and Family Services will be merged into the Department of Human Services July 1, 1998, Edgar's office said. ■

Rush gets approval for lung transplant center

[CHICAGO] The United Network for Organ Sharing recently gave Rush-Presbyterian-St. Luke's Medical Center the go-ahead to begin listing candidates for lung transplantation. The approval establishes Rush as a lung transplant center.

Effective immediately, the approval concludes the development of a complete transplantation service for Rush, a hospital spokesperson said.

Leading the program will be Steven Kesten, MD, as medical director, and ISMS member Alvaro Montoya, MD, as surgical director. Dr. Kesten was recently assistant professor of medicine at the University of Toronto, where he also earned his medical degree and completed training in respiratory medicine. Dr. Montoya graduated from the Antioquia University School of Medicine in Medellin, Colombia, South America, and completed his training at Loyola University Medical Center. He assisted with Loyola's first heart transplant in 1984 and served as director of Loyola's lung transplant program. He performed Loyola's first lung transplant in 1989, according to a news release. ■



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REPORT for Illinois Physicians

CASE SELECTION FOR HYSTERECTOMY

In the United States, over 500,000 hysterectomies are performed each year, with costs of at least two billion dollars¹. Recent analyses in managed care plans have shown a 16% rate of clinically inappropriate hysterectomies² with considerable variation occurring regionally and among individual practitioners³. It is no surprise that in recent years patients and payors of health care have become increasingly interested in a review of the selection criteria for hysterectomy.

Since utilization of appropriate selection criteria has the potential to improve quality of care and reduce costs, many institutions have included hysterectomy reviews in their quality improvement programs. Studies have demonstrated substantial decreases in hysterectomy rates by instituting selection criteria, complemented with case reviews that are correlated with tissue diagnoses. Over time, one well-monitored Quality Improvement Program was able to show a decrease in the recommendation of hysterectomies for chronic pelvic pain, recurrent uterine bleeding, pre-invasive disease, and adenomyosis⁴.

Studies have shown that the most common reasons for hysterectomy include leiomyoma (fibroids) and endometriosis⁵.

In recent years, criteria for appropriate use of hysterectomy have been published by specialty societies⁶ and institutions^{7,8}. These criteria can be used to evaluate the need for hysterectomy as the initial treatment for the following conditions:

- Small or asymptomatic fibroids
- Dysfunctional uterine bleeding without severe anemia or an adequate trial of medical therapy
- Pre-invasive disease without a trial of more conservative management
- Pelvic pain without a complete workup
- Asymptomatic uterine prolapse

Alternative therapies, including hormonal treatment or less-invasive therapeutic procedures, are available and can be considered in specific cases.

In addition to physician behavior, optimally, patient behavior must also be addressed.

The higher incidence of hysterectomies among women with lower levels of education⁹, speaks to the need for more aggressive outreach to provide early treatment and patient education. Open communication relating to risks, benefits, personal preferences, and expectations should be explored. This is especially important as hysterectomies are rarely done to treat life threatening conditions.

In short, a combination of a provider designed quality improvement program utilizing selection criteria, with monitoring, combined with detailed patient education, will allow realization of the potential for improved care, outcomes, and cost.

1. Easterday C.L.; Grimes, D.A.; Riggs, J.A. "Hysterectomy in the United States." *Obstet. gynecol.* 1983; 62: 203-212.

2. Bernstein S.; McGlynn, E.; Siu, A., et al. "The Appropriateness of Hysterectomy." *JAMA* 1993; 269:2398.

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EDITORIAL

Death, taxes and sore losers

There's nothing worse than a sore loser. Well, there may be some worse things – disease, death and taxes, to name a few. But sore losers can be a problem, particularly if they make allegations that don't take all the facts into account.

As you may recall, the Coalition for Consumer Rights was one of the groups that opposed H.B. 20, the law that was enacted in March 1995 and that set a cap on noneconomic awards in civil lawsuits and established other legal reforms. The coalition, which is funded by trial lawyer groups, held a news conference March 26 to release a report called "One Year Later: The Failure of Tort Reform." The title underscores the problem with the premise of the report: One year is not enough time to assess the law's effectiveness.

After an incident of alleged malpractice occurs, it takes at least five years for a resulting lawsuit to be resolved. The Illinois law is not retroactive to include lawsuits that arise from incidents that occurred before the legislation's effective date. As a result, it will take years for tort reform to achieve its full effect.

Even now, though, the law has had an impact. During the first two months of 1995, immediately before the law was enacted, 758 lawsuits were filed against physicians insured by ISMIE. But for the same period in 1996, the number of suits dropped to 264, a decrease of nearly two-thirds. Physicians who entered prac-

tice after the enactment of reform haven't been exposed to lawsuits under the unreformed legal system. As a result, ISMIE was able to reduce their premiums by 16 percent.

It would be reasonable to expect Illinois to follow in the footsteps of other states that have enacted caps. For example, in California, where tort reform took effect in policy year 1986, there was a lag time of about three years during which premiums actually increased and remained high. But by 1990, the average premium was 30 percent lower than the national average.

In its April 15 issue, AM News reported that a comprehensive 10-year study of civil court verdicts shows that compared with other forms of legal action, only a small proportion of medical malpractice suits result in verdicts for plaintiffs, but they are much more costly to defend than other types of lawsuits.

The Associated Press recently reported a general example of a system out of control. While on a playground in Boston, a 3-year-old boy kicked a little girl, after which the girl's mother obtained a restraining order and filed an assault-and-battery complaint against the boy. It seems that even childhood sandbox disputes are now actionable.

Illinois' tort reform law has already made a difference, but let's give it a chance to realize its full potential. ■

PRESIDENT'S LETTER

Around the world with your president

Raymond E. Hoffmann, MD



This has been a fantastic year. I've gone places, met people and done things I would never have been able to experience if I had not represented the best group of professionals in Illinois. The physicians of Illinois are highly respected because of all the time and effort they give to help their patients. People recognize the high-quality care rendered.

I've come to realize that there is a mantle that goes with the office of president. It is more than 150 years old and well-worn, but it is still strong. I have worn that mantle as I represented you. No, I didn't literally go around the world, though I feel as if I traveled as many miles in Illinois as it would take to see the world. But I did cover the world of the physician members of the Illinois State Medical Society.

Most of my time as president was spent on President's Tours – meetings that give each member in every county a chance to interact personally with ISMS. There were 49 trips all over the state. I tried to tie the all-time record – as far as I knew – of Dr. Gene Johnson's 50 trips, but at final count, I fell one short. I talked to more than 2,800 people, including 1,900 physicians, at the 62 events at which I spoke. Your hospitality was extraordinary. My wife, Nancy, and I can never thank you enough.

Traveling anywhere, anytime, I communicated Illinois physicians' and ISMS' interest in quality care. I wore the president's mantle to represent our members at the inauguration of the AMA's first minority president, Dr. Lonnie Bristow. I wore it at political events, meetings of other state societies and an affair that honored EMS workers in suburban Chicago. I wore it when I met with the governor about the need to keep the care of our patients' eye diseases in the hands of

physicians. I proudly wore it last February when I stood up for our patients and announced the introduction of the Managed Care Patient Rights Act into the legislature in Springfield.

You should know how far and wide your society is represented. You should also know how much regard there is for our organization. It felt good to stand up and say that I was the president of an organization that represents the best profession.

There will be many memories from this year – memories of miles traveled, photos with Superman in Metropolis and dinners all over the state including Muddy, Ill. But the best memories will be of the compassionate, dedicated physicians I've met all over the state.

By now the House of Delegates meeting is over, and we have new officers. I know we will be in good hands with our new president, Dr. Sandra Olson. With the same generous amount of help you gave to me, she will lead us very capably.

As I end this incredible year, I must again thank you all for everything. I have found it takes a great number of people working hard to make one president look good. The ISMS staff get the highest praise. My partners and staff at Rockford Surgical Service have supported me without question. My family has been wonderful. My wife gets special praise, as she has traveled with me on 25 visits, heard my speech each time and critiqued each "President's Letter."

The hard effort, the long hours, the travel, the lost sleep and the many phone calls have all been worth it. You have made it so. Because of physicians like you, medicine is the best profession there is.

Thank you. ■

*The best memories will
be of the compassionate,
dedicated physicians I've
met all over the state.*

GUEST EDITORIAL

Keep medical secrets a secret

By T. Evan Schaeffer

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These days, profound changes are under way that threaten the confidentiality of medical records – records that contain not only the potentially embarrassing medical secrets patients tell their doctors, but details about where they live, what they earn and other personal information that can be used, or misused, for a variety of purposes. With changes in the way these records are stored, maintained and exchanged, patient privacy is at risk as never before.

The old paper-based system of recording medical information – inefficient perhaps, but easier to keep private – will soon be a thing of the past. What's replacing it? Computerized systems in which patients' secrets are transmitted through cyberspace from their treating physicians to insurers, oversight agencies and others with an interest in the cost of medical care.

With the growth of HMOs and health networks, these computerized systems often include electronic depositories of patient information, which insurers and others can access from remote locations throughout the country. No one tells you who's looking, because no one is required to.

A further complication is the rise of commercial information companies. In 1995, Equifax – the country's largest dispenser of credit reports – announced its intention to enter the computerized medical records industry. Although a joint venture between AT&T Corp., Equifax and others has been temporarily put on hold, Equifax still intends to tap into this growth industry.

In the meantime, Equifax has issued public assurances that it is opposed to the use of medical information for marketing or other nonmedical purposes. Nonetheless, it won't be long before some enterprising company, taking advantage of the loopholes in existing legislation, begins putting medical information to creative – and perhaps sinister – uses.

Medical information has become a commodity. And when patients' secrets can be bought and sold, patients should be concerned about who is looking at their medical records and why.

Many think the confidentiality of their medical records is protected by federal law. Not so. Though a proposed federal law – the Medical Records Confidentiality Act of 1995, called the "Bennett bill" – is being considered by the Senate, the privacy of medical records is now governed only by state law. Many states, however, don't protect the confidentiality of medical records. Those that do don't always grant patients the right to obtain a copy of their own records.

Clearly, the time is right for uniform federal legislation, which should contain the following provisions:

- Patients should have complete access to their medical records – no exceptions.
- Access to others should be strictly

limited to treating doctors or those with a need to know, rather than to any hospital or insurance company employee with a networked computer.

- Patients should be notified when their medical information is transmitted from their treating physician to others.

- Patients should be allowed to decline participation in electronic databases without fear of reprisal from insurers.

Of course, doctors and hospitals also have an important interest in laws governing patient confidentiality. Doctors desire a strong law that will encourage a frank exchange of information with their patients. Doctors and hospitals both desire clear, bright line rules for disclosure of information to others, so that they don't have to worry about legal liability whenever they are confronted with an outside request for records.

With these various benchmarks as a guide, the federal legislation being considered by the Senate is seriously flawed. Sponsored by Sen. Robert F. Bennett (R-Utah), the bipartisan-supported bill is being considered by the Senate Labor and Human Resources Committee.

The committee should be busy, since in its present form, the bill does very little to protect patient privacy. It sanctions the creation of computerized data banks of medical information – all without patient consent. It provides patients no opportunity to decline participation in data banks and actually makes insider access to medical information easier than it was before. And though the bill allows patients to obtain their records and attempt to correct errors, the exceptions to these rights swallow the rule.

Surprisingly, the Bennett bill would also pre-empt – in other words, abolish – all state laws and judge-made rules concerning medical records, thereby wiping out consumer-friendly legislation in those states that have made patient confidentiality a priority. This is astonishing, until you consider that differing state standards would create huge administrative problems for those information megabusinesses like Equifax that are involved with medical records on a nationwide scale.

Since 1994, patient confidentiality has been a key feature of virtually every health care bill considered by Congress. It won't be long before one of them – whether the Bennett bill or some other – is passed into law. Sen. Bennett's office expects that a revised draft of the bill will be considered by the full Senate later this year.

Consumers should take an interest in the end result. Though a 1993 Harris-Equifax poll on medical privacy found that 80 percent of respondents said they believed they no longer had control over the way their private information is circulated in the computer age, this doesn't have to be the case. Consumers can and should demand that the secrets they tell their doctors remain confidential. ■

Schaeffer is an attorney at Thompson Coburn in St. Louis.

Quotables

"Everybody thinks we are arrogant. It's almost as if we have to prove we're nice people. We're judged arrogant because we have MD next to our name."

— **Paul O. Farr, MD**, on myths and misconceptions about physicians, Michigan Medicine

"Both men and women are given to radically exaggerating work hours. They over-report activities with social desirability like work hours or child care."

— **Frank Stafford**, an economist at the University of Michigan, on a study that showed Americans routinely underestimate their leisure time and overestimate their work hours, Chicago Sun-Times

"These giant health care mergers are happily galloping toward an oligopoly."

— **Sara Nichols**, Washington director of the nonprofit Physicians for a National Health Care Program, on the merger of Aetna Life & Casualty Co. and U.S. Healthcare Inc., Time

"I personally feel we can't base all our clinical practice and guidelines purely on randomized clinical trials."

— **Sidney Winawer, MD**, chief of gastroenterology at Memorial Sloan Kettering Cancer Center, on his support for the aggressive approach of Kaiser Permanente of Northern California in screening its HMO members for colon cancer, Wall Street Journal

"Scrambling is kind of like going through the banquet line after everyone else has gone through for firsts."

— **William Mootz**, assistant dean at St. Louis University Medical School, on "Scramble Day," when fourth-year medical students who didn't match try for leftover residency openings, St. Louis Post-Dispatch

"My medical judgment was in question. Every time third parties succeed in challenging our judgment as physicians, they erode our professional authority and credibility. That's why I demand a reasonable explanation for each payment denial."

— **Corey Marco, MD**, family physician in Cajon, Calif., on why he spent time and legal fees to fight a \$267 denial by a third-party payer, Medical Economics

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ISMIE Update

ISMS and ICJL respond to criticism of 1995 tort reform legislation

RESULTS: Benefits of law will take time to be realized. BY JANICE ROSENBERG

[CHICAGO] At a March 26 news conference in Chicago, the Coalition for Consumer Rights – a group that receives funding from trial lawyer organizations – released a study claiming last year's tort reform legislation has failed to boost Illinois' economy. Among the legislation's provisions was a \$500,000 cap on noneconomic damage awards in civil lawsuits. The law was enacted March 9, 1995, when it was signed by Gov. Jim Edgar.

Employment figures, construction starts and other economic indicators, including the

number of lawsuit filings, have all worsened in Illinois since March 1995, according to the coalition. Its study cites an increase in medical malpractice premiums as an example of how the law has failed to benefit Illinoisans.

Most lawsuits filed in Illinois after the law was signed involved incidents that occurred before the law's effective date and thus could not be covered by the legislation, said Edward Murnane, president of the Illinois Civil Justice League, which along with ISMS, worked to achieve passage of the bill. "The

coalition knows that the true impact of the Civil Justice Reform Amendments of 1995 will not be felt for several years," he told Illinois Medicine. "In testimony before committees, in our public statements and in the debate on the floor of the House and Senate, we stated the facts, including the fact that results were not going to be seen immediately."

"It takes five years or more after an incident of alleged malpractice occurs for a lawsuit resulting from it to be resolved," said Harold L. Jensen, MD, chairman of the

ISMIE Board of Governors. "Since the reform law is not retroactive to include suits arising from incidents occurring before the effective date, it will take years for lawsuit reform to achieve its full effect. All patients and physicians will benefit greatly from this vital reform once it has had an appropriate amount of time to become fully effective."

AT THE NEWS CONFERENCE, Gail Siegel, the coalition's program director, said, "ISMIE blamed jury verdicts for their 15 percent rate hike in 1994 and said they needed caps to hold down rates. However, after caps were enacted in H.B. 20, ISMIE raised their rates 9 percent, faster than consumer prices or medical prices."

"There were 758 lawsuits filed against doctors insured by ISMIE in the first two months of 1995 – immediately before tort reform was enacted," Dr. Jensen said. "For the same period in 1996, the number of suits had dropped to 264 – a decrease of nearly two-thirds. Lawsuit reform is working as it was intended."

ISMIE was able to reduce its

premiums by 16 percent for new doctors entering practice after the reform's enactment, because those doctors will not be exposed to suits under the previous unreformed legal system, Dr. Jensen explained.

The number of suits in critical areas of litigation has actually decreased in some jurisdictions of Illinois since enactment of tort reform, according to the Illinois Civil Justice League. For example, in Cook County, the largest jurisdiction in the state, a comparison of the six-month period after the enactment of the new law with the same six-month period the previous year shows a 40 percent reduction in the number of suits involving medical malpractice, product liability and premises liability.

"If so-called consumer groups are truly concerned about a fair legal system, they should join the members of the Illinois Civil Justice League in defending lawsuit reform and upholding this expression of the will of the people of Illinois against the well-funded challenges raised by those who profit from the litigation industry," Dr. Jensen said. ■

MALPRACTICE ROUNDUP

Jury finds hospital's transfer of patient resulted in death

In *Barris vs. County of Los Angeles*, a California jury awarded \$1.3 million to the family of a child who died of sepsis after a county hospital transferred her to another facility without conducting any diagnostic tests or providing any treatment, according to the March issue of *Medical Malpractice Law & Strategy*.

The patient had a temperature of 106 degrees and was experiencing breathing difficulty, vomiting and diarrhea when she presented at the county hospital's emergency department. While there, she suffered a seizure. The emergency physician recommended transferring her to a Kaiser hospital, since she was a member of its plan, and the doctor at that hospital asked that no testing be done at the county hospital. After the patient was transferred, she experienced cardiac arrest, which resulted in her death, the story said.

The patient's family alleged that the county hospital violated the federal Emergency Medical Treatment and Active Labor Act by failing to stabilize her before the transfer and that it caused her death by failing to diagnose and treat her sepsis. In addition, the family claimed the Kaiser hospital and its physician were negligent in requesting the transfer and in advising the county physician not to test her. All the defendants maintained their actions fell within the standard of care and the patient's death was caused by untreatable congenital asplenia, according to the article.

The jury found the county hospital and its physician 75 percent liable and the HMO and its physician 25 percent liable, the story reported. ■

Physician had immunity for deposition testimony

In a medical malpractice case, a physician who gave deposition testimony that was unfavorable to his patient was found to have immunity from the liability that arose from that testimony, according to a 7th Circuit Court decision reported in the April 15 edition of the *National Law Journal*.

In *Giffin vs. Summerlin*, a patient sued his current physician for giving unfavorable testimony in a malpractice suit the patient had brought against his former physician. The patient claimed that the physician being deposed owed him a duty to refrain from helping the defendant doctor and that the breach of that duty constituted a violation of the confidential physician-patient relationship. The district court granted summary judgment for the physician, finding that the patient waived the privilege in filing his action, the story said.

The circuit court noted that Indiana courts have long provided witnesses with immunity from civil suits for their testimony in judicial proceedings. It concluded that the threat of a suit for damages could intimidate a witness who testified by deposition as much as one who testified in court, according to the article. ■

ISMIE offers seminars on lawsuit management, risk management

ISMIE is offering the seminar "Taking Control: Managing Your Malpractice Lawsuit" May 8 in Springfield. The session, which runs from 5:30 to 8 p.m., was developed for ISMIE policyholders who have been named as defendants in medical malpractice lawsuits and their spouses.

At the program, ISMIE claims personnel and physician and attorney speakers will explore the discovery, claims management and trial processes, as well as ways in which physicians can play an active role in their defense and cope with the emotional stress of litigation.

In addition, ISMIE is offering a seminar on office risk management to be held at various sites statewide through early November. The sessions, which begin at 9 a.m. and end at noon, focus on how office

staff can use risk management procedures to help physicians provide better-quality medical care, prevent patient injury and reduce the chances of being sued.

Specifically, each seminar will cover patient communication, record access and retention, patient follow-up, managed care issues and billing and collection. The sessions are recommended for physicians, office managers, nurses, receptionists, business managers and all other medical staff personnel.

To guarantee a seat at the office risk management seminar, attendees must complete a registration form, which can be obtained by calling ISMIE's risk management division at (312) 782-2749 or (800) 782-4767. Physicians may call the same number to register for the lawsuit management program. ■

ACCESS

Health on wheels

Special services help patients get to their doctor appointments and receive testing at convenient locations.

BY JULIE A. JACOB



Sometimes a driver for the Southern Seven Health Department pulls up at a client's home well before dawn. She helps the client – usually a pregnant woman or a mother with small children who need care – prepare for the trip to the hospital or clinic. She may even feed or dress the children while the client gets ready.

Then at no charge, the driver takes the woman and children as far as 90 miles to get to a physician's office or a hospital in Carbondale, Springfield, St. Louis or Chicago for prenatal or well-baby care. Driving across rural Illinois may not be the most convenient way for women in Illinois' southern seven counties to receive prenatal care, but for many it's the only way, said Sharon Mumford, administrative director for the Southern Seven Health Department, which has jurisdiction over Alexander, Hardin, Johnson, Massac, Pope, Pulaski and Union counties.

According to Mumford, the counties have a total population of 81,000 in an area the size of Delaware, and the largest town has only 8,000 people. The average annual income is \$11,000, and many residents are Medicaid enrollees.

In the mid-1980s, the area was targeted for assistance by the state because of its high infant mortality rate, Mumford said. Ob/Gyns and hospitals are scarce in the area, with only three of each. So, many women must travel long distances to receive prenatal care but don't have access to a car. Not surprisingly, a study conducted in the '80s showed that prenatal care in the area was impeded by a lack of transportation to health care facilities.

THE SOLUTION was to have someone drive the women to their doctor appointments. So in 1986, the program, funded by the Illinois Department of Public Health and the Illinois Department of Public Aid, began with one driver who waited for calls from women who needed rides to doctors' appointments. But the demand soon exceeded the program's capacity, so additional drivers were hired, Mumford said.

Today six drivers use their own cars to take pregnant women and mothers with their small children to health care appointments. Last year they traveled a total of 275,248 miles carrying 1,125 clients to 3,795 medical appointments.

The program must be doing something right: The infant mortality rate in those counties has dropped from 15.6 per 100,000 in 1986 to eight per 100,000 in 1994, according to IDPH. And the cost was less than \$200,000 a year, Mumford said.

One key to the program's success is the transporters' dedication to their jobs, Mumford said. For example, one driver applied for the job after her triplets were born several weeks prematurely and died. That experience made her determined that other women would have access to prenatal and well-baby care.

The transporters need more than commitment, though. They must complete training in defensive driving, cardiopulmonary resuscitation, basic first aid and child care and safety.

The drivers also serve as a vital communication link

because only 40 percent of residents in the seven counties have telephones, Mumford said. So physicians may ask the drivers to stop at patients' homes and relay information about upcoming appointments and tests.

Several other four-wheeled programs help Illinoisans obtain such services as mammograms, heart exams and immunizations. Since 1994, Saint Joseph Hospital of Elgin has helped almost 2,000 women receive mammograms through its Mobile Diagnostic Services program, according to Jacqueline Szymanski, administrative director of the hospital's diagnostic imaging services. She said she wanted to start a mobile mammogram service because so many women skip screenings because they can't take time off from work or are afraid to go to the hospital.

TWO YEARS AGO, Szymanski asked the Saint Joseph Hospital Foundation to donate the cost of a \$165,000 health services van, including a computer to register patients, a generator, a darkroom, X-ray equipment, air conditioning, heating, and phone and electrical hookups. The hospital uses its own mammogram equipment. "The mobile van meets all the same criteria for accreditation as equipment inside the hospital," Szymanski explained.

The van travels to corporations, health fairs, shopping malls and churches, and the cost of a mammogram is slightly less than it would be in the hospital, Szymanski said. Women do not need an order from their physicians to get a mammogram, but they are encouraged to share the results with their doctors. Szymanski said she knows of at least five women whose early breast cancer was detected and successfully treated as a result of a mammogram through the van program.

When not in use for mammograms, the van travels to low-income neighborhoods to provide on-site child immunizations and is used as a first-aid station at local athletic events. In addition, Saint Joseph's Care-a-Van program transports radiation therapy patients to and from their appointments, said Nancy Blasi, the hospital's executive director of development and public relations. Last year the van, which was purchased through donations, made almost 3,000 trips.

In Springfield, St. John's Hospital introduced a mobile heart exam service last year. A van outfitted with echocardiography equipment and staffed by St. John's ultrasound technicians travels to satellite clinics at small hospitals in central and southern Illinois. Most of the towns – including Pittsfield, Litchfield and Hillsboro – are within 90 miles of Springfield, said Bonnie Flynn, St. John's administrative director of cardiovascular services. The van is equipped to provide echocardiograms and other noninvasive vascular diagnostic tests.

St. John's cardiologists read the tests the same day they're taken and fax the results to the patients' physicians within 24 hours. The mobile echocardiography service tests about 100 patients a month, Flynn said. "Smaller hospitals don't have the volume of patients to sustain echocardiography services. By using the mobile testing service, patients can receive the same quality of care as at larger institutions without having to be transported to Springfield." ■

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Dawn R. Hamman

OSF HealthCare System
Saint Francis, Inc.
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Peoria, Illinois 61614
Phone 800-438-3740
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HHS issues

(Continued from page 1)

In February, ISMS announced that the Managed Care Patient Rights Act had been introduced in the General Assembly. The bill aims to instill confidence that health care providers are advocating on patients' behalf for medically necessary health care and to entitle patients to clear and understandable information about the terms and conditions of their health care coverage.

The final HHS rule, which imple-

ments the 1990 budget reconciliation law, applies to doctors who provide medical care through HMOs, competitive medical plans and health insuring organizations. Noncomplying Medicare or Medicaid managed care contractors may face intermediate sanctions from HCFA and civil monetary penalties from the HHS Office of Inspector General, HHS said.

The final HHS rule, published in the March 27 Federal Register, has a 60-day comment period and will take effect 30 days after publication, according to HHS. ■

HIV-infected woman

(Continued from page 1)

consistent with, but more stringent than, the test kit manufacturer's criteria. Such rules were recommended in a Jan. 3, 1994, FDA memo that was distributed to all registered blood and plasma establishments, including Heartland, the complaint said.

Heartland Blood Centers disputes the plaintiff's claim. "The facts are clear that the FDA's strict procedures for testing of blood used in transfusions were fully followed," said Heartland's Medical Director Franklin Farrales, MD. "Heartland Blood Centers was one of the first blood centers to adopt the advanced HIV testing procedures and continues to have one of the safest blood supplies in the country. It appears that this infection was impossible to prevent." There is "a

very small risk that viruses, such as the HIV virus, may be transmitted through a blood transfusion," Dr. Farrales said, adding that Schieben acknowledged that risk when she signed a waiver.

But Schieben "did not sign any waiver that would protect the blood bank," according to her attorney, Robert Clark of Hoeppner, Wagner & Evans in Valparaiso, Indiana. He and the Schiebens hope through this lawsuit to "ensure that a blood bank does not use blood that tests positive," Clark said. "The blood-shield statutes in Indiana and Illinois say that blood banks are solely responsible for testing, so they're the legal and social gatekeepers of safe blood. And since they're the gatekeepers, they can't pass the responsibility [for the product's safety] on to the doctor and hospital."

The blood supply in general is safe, "particularly since the institution of tests

Postpartum care bills pass House, Senate

[SPRINGFIELD] Mandatory minimum maternity stays received overwhelming support last month when state legislators approved two bills requiring insurers to pay for at least 48 hours of inpatient care following a vaginal delivery and 96 hours of inpatient care following a birth by cesarean section. The legislation was designed to stop drive-through deliveries.

H.B. 2557, sponsored by Rep. Kay Wojcik (R-Schaumburg), passed the House March 27 by a vote of 111-2. One day

later, the Senate unanimously approved S.B. 1246, sponsored by Sen. Robert Madigan (R-Lincoln). Both bills allow for earlier discharge but only when attending physicians decide a shorter stay would not pose a risk to mothers or infants.

"I am absolutely elated," Wojcik said. "This has been a long time in coming. Giving birth is a beautiful experience, and women shouldn't have to be watching the clock. This also puts less pressure on physicians to get the female out of the hospital." ■

for HIV," said John Lumpkin, MD, director of the Illinois Department of Public Health, who expressed concern for Schieben and her family. "But there is a one in 450,000 to 660,000 risk [of infection] even with screened blood." Eighteen to 27 infectious donations are available for transfusion annually out of an estimated 12 million collected, said IDPH spokesperson Tom Schafer, citing a recent article in the New England Journal of Medicine.

Springfield pathologist Victor Lary, MD, the Central Illinois Community Blood Bank's medical director and a member of the IDPH Clinical Laboratory and Blood Bank Advisory Board, concurred with Dr. Lumpkin. "The blood supply has never been safer than it is right now. Blood banking, in general, is probably the most regulated aspect of laboratory medicine and probably of medicine in general. But the standard

we're being held to is zero risk. And you don't even get zero risk walking across Michigan Avenue [in Chicago]. The risk of getting an infectious disease from a blood transfusion is less than the risk of [being hit while] walking across Michigan Avenue during rush hour."

The risk comes from a one- to three-week "window of infectivity," according to Dr. Lary. "If someone is infected with HIV, there is a short period of time that the person has the virus, probably does not know it and is contagious, but the antibody doesn't show up. If the donor [gives blood] in this window and the antibody test is not positive, the infected blood conceivably could be donated." A procedure federal regulators licensed in March, however, tests for the HIV antigen instead of the antibody and "is closing the window of infectivity to increase the safety of the blood supply even more," Dr. Lary said. ■

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Illinois Medicine

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1996 ISMS
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highlights

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ISMS delegates debate key issues at Annual Meeting

RESOLUTIONS: Physicians discuss restrictive covenants, advance directives and public health problems. BY KATHLEEN FURORE

[OAK BROOK] Physician delegates acted on 95 resolutions during ISMS' Annual Meeting of the House of Delegates in Oak Brook from April 19 through April 21. Delegates debated resolutions in reference committees, and their overall comments formed the basis for reports distributed to the House. Then delegates considered and discussed the resolutions again on the House floor before voting on them. An overview of their actions begins in this issue and will continue in future issues.

RESTRICTIVE COVENANTS

Debate was stimulated by a resolution calling for ISMS to adopt as policy that physicians "shall not be a party to or participate in" employment agreements with restrictive covenants. Most of the testimony supported the resolution and centered on concerns that restrictive covenants in employment agreements between such companies as insurers and physicians are unfair to doctors and limit patient access. The resolution also directs ISMS to "cause legislation to be introduced in Illinois" that abolishes agreements that restrict physicians' right to practice medicine. One delegate noted that

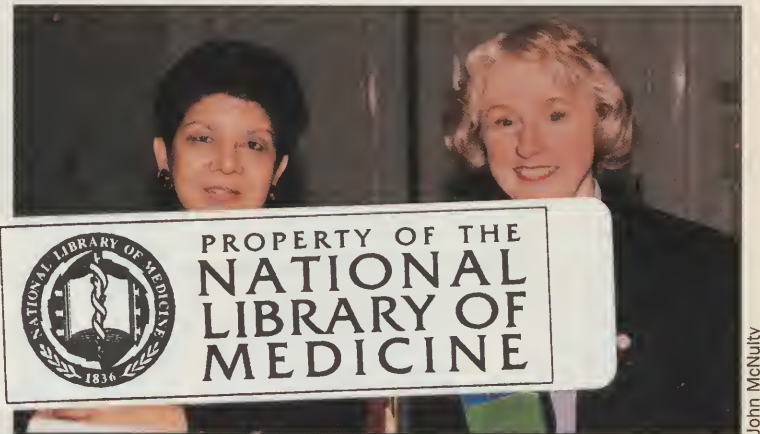
physicians already have the right to negotiate contracts and can refuse to sign agreements containing restrictive covenants. But others noted that physicians who refuse to sign such agreements may not be offered jobs.

The case of Berlin vs. Sarah Bush Lincoln Health Center was discussed in the context of the resolution. Although the suit was prompted by Dr. Richard Berlin's challenge of a restrictive covenant with the health center, at issue was the corporate practice of medicine. The House supported the reference committee's recommendation to adopt the original resolution.

ADVANCE DIRECTIVES

Implementation of patients' end-of-life decisions was the subject of a resolution that prompted substantial discussion. One delegate noted that media reports have blamed physicians for providing care against patients' wishes as outlined in patients' advance directives. The resolution asks the Society to request legislative or regulatory changes that would allow abbreviated advance directive information to be included on driver's licenses or state-

(Continued on page 15)



John McNulty

SANDRA OLSON, MD (right), ISMS' incoming president, and **Silvana Menendez, MD**, outgoing first vice president, relax during a break in the floor debate at the recent House of Delegates Annual Meeting in Oak Brook.

Berlin decision upheld

RULING: Appellate court says health center violated statute prohibiting corporate practice of medicine.

BY KATHLEEN FURORE

[SPRINGFIELD] On April 12, the Fourth District Appellate Court upheld a lower court's ruling in Berlin vs. Sarah Bush Lincoln Health Center that the hospital's employment contract with Richard Berlin, MD, was unenforceable because the Charleston center is licensed as a not-for-profit corporation and cannot engage in medical practice. Such practice, a Coles County trial court previously noted, violates the Medical Practice Act, which says only individuals licensed to practice medicine may do so.

"We hold that the trial court did not err in granting Dr. Berlin's motion for summary judgment based on its finding that the health center, through its general surgery employment agreement with Dr. Berlin, violated the statutory prohibition on the corporate practice of medicine," Justice Robert Steigmann wrote. The court also pressed the point that changes to exempt hospitals from the doctrine prohibiting the corporate practice of medicine are best left

to the legislature, not the courts. "The legislature thus far has not acted," Steigmann wrote, "and until it does, we will continue to follow existing law." The hospital plans to appeal to the Illinois Supreme Court.

The case dates to 1994, when Dr. Berlin resigned from the health center and started working at the Carle Clinic Association's Mattoon-Charleston branch, one mile from Sarah Bush Lincoln. He had signed an employment contract with Sarah Bush Lincoln in 1992 that prohibited him from affiliating with "any person, firm or corporation engaged in competition with [the] hospital in providing health care services within a 50-mile radius" during the agreement's term and for two years afterward.

The health center soon filed suit to enjoin Dr. Berlin from practicing at Carle. He ultimately left Carle and set up private practice but sued the hospital, seeking a declaratory judgment that the contract's restriction

(Continued on page 14)

Kansas City insurers drop gag rules from contracts

MANAGED CARE: Medical society works with insurers, media. BY LYNN KOSLOWSKY

[KANSAS CITY] When the New England Journal of Medicine published "Extreme risk: The new corporate proposition for the physician" in its December 1995 issue, it did more than generate interesting reading. The article, which focused on the U.S. Healthcare HMO, helped start a chain reaction in Kansas City by piquing the interest of Richard Hellman, MD, chairman of the National Government Affairs Committee for the Metropolitan Medical Society of Greater Kansas City. "Gag rules were such an effective device for U.S. Healthcare that I thought some other insurers must be using them too," he said.

While Dr. Hellman was reading the journal, the staff of the Kansas City Star newspaper was reading national coverage

of gag rules, according to Julius Karash, the Star's health care reporter on the business desk. After attending a managed care trade group conference in Washington, Karash recognized the importance of the issue, he said. "I thought it was an intriguing, powerful story and that it was incumbent on me to cover it. I figured that since it was a problem nationally, it might be in our area."

After visiting the Star's editorial board and discussing gag rules, the medical society joined forces with the newspaper, according to Lorell R. LaBoube, the society's director of public affairs. "We talked about gag rules, and [the newspaper] asked for samples. Physicians were hesitant to step forward

(Continued on page 2)

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Program offers
physicians one-
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Market STATS

Despite scares, breast implants still popular

Despite recent scares about leaky breast implants, the popularity of breast-augmentation surgery continues to grow, reported the Arlington Heights-based American Society of Plastic and Reconstructive Surgeons, with at least two-thirds of implant procedures done for repeat customers. In 1994, 68 percent of women who had implants removed also had them replaced right away, up from 60 percent in 1992.

American Demographics
January

Don't use Medicare to balance the budget

Two-thirds of adults 55 and older would not want to see their monthly Medicare premiums increased to help balance the federal budget, according to a survey by the Aragon Consulting Group. Among those who don't oppose an increase, 27 percent would be willing to pay an increase of less than \$10 per month, and 10 percent would be willing to pay at least \$50 extra per month.

USA Today
March 5

Gender-based pay gap closes

Young male and female physicians receive virtually equal pay these days for the same kinds of work, according to a study published in the New England Journal of Medicine. An assistant professor of economics at Stanford University said the two genders earn almost the same amounts when differences of specialty, hours worked and practice setting are taken into account. The researcher said that young women doctors, however, often choose specialties that pay less than those men choose.

New York Times
April 11

Tally of cancer info line is 6.5 million and counting

The Cancer Information Service of the National Cancer Institute, marking its 20th anniversary this year, can look back on 6.5 million telephone calls received during its existence. Begun in 1976, the CIS disseminates information on cancer prevention, detection and treatment to the public. Its 19 offices around the nation now field about 600,000 telephone calls a year. The toll-free number is (800) 4-CANCER.

Chicago Sun-Times
April 7



"I'm just reminding the doctor about the gag rule in his managed care contract. He can't discuss treatment options."

Kansas City insurers

(Continued from page 1)

[to provide contracts], so we accepted them anonymously. Once we came up with a critical mass of four or five, we approached the Star and the insurers."

Specifically, the medical society identified four examples of gag rules and one example of a disparagement clause, Dr. Hellman said. He noted that even if clauses don't restrict physician-patient communication regarding treatment options, contract language is a problem if it "intends to interrupt free communication between doctors and patients and is to the benefit of insurers."

Before meeting with the Star to review the contract examples, the medical society called the insurers, Dr. Hellman explained. "I said I'd be meeting with the press and wanted to give a heads up that we had identified a gag rule in their contracts." Blue Cross and Blue Shield of Kansas City "talked to a lawyer, an ethicist and a publicist and said there were ethical problems with that clause, and they decided to change it."

THE BLUES' CONTRACTS "asked [physicians] who had problems with the procedures or rules not to complain to patients; complain to us," said Leigh Elmore, a spokesperson for the Kansas City Blues. "The local medical society here made an issue of it, and we just decided that we should get rid of these disparagement clauses and move on. You can't win a war of words in the press on fairly technical interpretations of things. We said, 'This is not worth fighting. We can change these clauses.'"

Another insurer, HealthNet Inc., decided to drop its language about 27 hours after having been contacted by the medical society, Dr. Hellman said. The third insurer, St. Luke's Hospital in Kansas City, had a gag rule in its PHO, according to Dr. Hellman. "We asked them to remove it, and they did."

The other two insurers were not as cooperative, Dr. Hellman said. "Kaiser Permanente said, 'If doctors are willing to gag themselves [by signing the contracts], the medical society should lay off.'" So, Dr. Hellman called John Traub, the legislative director for U.S. Rep. Greg Ganske, MD (R-Iowa), a sponsor of a federal bill that would prohibit gag rules. "He called the Kaiser lawyers at the national office and received verbal assurance they would

remove such clauses. Affordable Health Care Concepts sent us a letter saying that such language is irrelevant and had been replaced."

The Star ran a page-one news story and two editorials on gag rules, Karash said. Dr. Hellman noted that without press coverage, the medical society's efforts wouldn't have been as effective. "Public opinion is what [the insurers] were sensitive about. The newspaper was acting in the public interest, and the medical society was acting in patients' interest."

But Elmore said that press coverage of managed care has been "bad. The press forgets that eight years ago, [it] was howling about the high cost of medical care, and the market was saying, 'Do something about costs.' The market did something, and now we're getting a reaction."

"General Motors and Ford and the big groups have been on this issue for many years on the cost side," Elmore continued. "They have been instrumental in the formation of the NCQA [National Committee for Quality Assurance] accreditation process to uphold quality in HMOs."

The medical society plans to take the issue to state and federal levels next. Dr. Hellman said the society will encourage the Kansas and Missouri state medical societies to consider developing legislation modeled after the bill that passed in Massachusetts in January.

In addition, an officer of the Kansas City medical society is scheduled to testify before Congress in May, Dr. Hellman said. "He was recruited to join a network, and when he realized he would not be able to deliver [certain] services to patients, he withdrew [from the network] and sent a letter to his patients explaining his reasons. The company threatened him with a lawsuit."

"This is a patient rights issue," Dr. Hellman added. "Gag rules set informed consent back 20 years." ■

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Program offers physicians one-on-one computer training

SERVICE: The Lake County Medical Society helps its members become computer literate. BY RICK PASZKIET

[VERNON HILLS] Thanks to a computer education program kicked off last fall by the Lake County Medical Society, 40 physicians have learned to send and receive E-mail messages, use word processing and spreadsheet software programs, research subjects on CD-ROM and gain access to the Internet.

"With their busy practices and demanding schedules, doctors simply don't have the necessary time to learn basic computer skills," said Jane Stein, executive director of the Lake County Medical Society. "We developed this program as a convenient and useful way for doctors to learn about computers in a comfortable environment.

"One reason for the program's success is that physicians have personalized, one-on-one instruction," she said, adding that the sessions were designed for novices and aim to make computers less intimidating. "The physician can explain to our instructor what he or she

me the necessary tools to understand how a computer can assist me."

Dr. Furman said the training gave him an overview of various software programs and, most important, generated ideas on improving his practice's handling of medical records.

"As a surgeon, I don't need a computer to do my job," he said. "But as an educational and organizational tool, it's a great asset. I believe that computer knowledge is essential for the physician involved in managed care who needs to keep track of a high volume of HMO patients."

The training sessions are taught by a computer science teacher from a Deerfield junior high school, who explains computer capabilities and then instructs the physician on software programs in which the doctor is interested.

The training encourages doctors to put their training into action by using a computer on a daily basis. "In our med-

ical society office, we have a computer that's for the sole use of our member physicians," Stein said. "They can come in at any time and use our various software programs."

In addition to the one-on-one sessions, the Lake County Medical Society offers instruction at a Lincolnshire school for a discounted fee, Stein said. The classes are kept small, last between two and three hours and are exclusively for physicians. That format allows the instructor to focus on physician applications and provides more in-depth training than the basic sessions do, she added. ■

*My brief instruction
allowed me to learn
how a computer can
make my life easier.
In fact, I just purchased
a laptop computer so
that I can work more
easily at home.*

wants to learn. The whole purpose of this program is to show doctors how a computer and its various functions can help them in their own medical practices." Each session lasts about one hour and is free, she said.

"In some respects, I consider myself to be a computer illiterate," said Neda Tkalecic, MD, a Waukegan dermatologist who participated in a session. "Without computer skills, you almost feel like an outcast of society. I realized that I needed to start using computers. Of course, we have them in the office, but my lack of computer knowledge and training cut off my involvement."

Dr. Tkalecic said her goal was learning WordPerfect and accessing dermatological data on CD-ROM. "One training session at the medical society showed me the basics - it opened the door for me. My brief instruction allowed me to learn how a computer can make my life easier. In fact, I just purchased a laptop computer so that I can work more easily at home."

"Doctors who weren't brought up with computers have a limited understanding of what they can accomplish," said Richard Furman, MD, a general surgeon in Gurnee. "Since I have only a very rudimentary knowledge of computer programs, I thought that the one-on-one instruction offered by the medical society would give



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REPORT for Illinois Physicians

Medicare Orthopedic and Cardiovascular Centers of Excellence Demonstration

Premier cardiovascular and orthopedic facilities offering beneficiary incentives and reduced costs to the Medicare program will receive "Participating Centers of Excellence" designations under a new demonstration project being undertaken by the Health Care Financing Administration. The goal of the demonstration is to convey special Medicare status on premier heart and orthopedic facilities offering additional benefits to beneficiaries and lower prices to the Medicare program. The demonstration will offer high volume, quality individual hospitals and associated physicians an opportunity to enter a global bundled payment arrangement for selected cardiovascular and orthopedic procedures. Beneficiaries may benefit from lower cost-sharing, simplified claims administration, lodging support, or other specialized attention.

The demonstration will be limited to a selected group of cardiovascular procedures and/or a group of orthopedic procedures defined by specific Diagnosis Related Groups (DRGs) and Current Procedure Terminology (CPT) codes. The cardiovascular option includes heart bypass graft surgery, cardiac valve procedures, angioplasty, and cardiac catheterization. The orthopedic option includes total joint replacement for the hips and knees.

The demonstration also will test the use of systems for administration, claims processing and payment and the routine monitoring of care. The overall performance of participating centers of excellence will be evaluated by HCFA in a separate set of activities.

The demonstration centers will be selected on a regional basis and must meet volume and high-quality standards. Participating institutions will be designated as a Medicare Participating Center of Excellence, which can be used as a potential marketing tool to change referral patterns and increase patient volume. Beneficiaries will continue to have free choice of providers. At the same time, the Centers are expected to offer beneficiaries incentives, such as lower cost-sharing, simplified claims processing and transportation to and from the facility.

Following intensive review, invitations to submit a full application will be extended to providers who can document in their preapplications that they meet the basic qualifications for participation and have the potential to submit well-designed proposals addressing the criteria to be applied in the final review and site selection process. Other information to be examined in extending invitations to submit full applications include facilities' capacity to handle potential increases in volume and the ability of their internal data systems to support the planned evaluation.

Successful applicants are those that can demonstrate the ability of the hospital to deliver the highest quality of care efficiently and that can offer a viable program proposal to implement and manage a successful demonstration. Up to 100 facilities are expected to be designated as a Medicare Participating Center of Excellence.

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EDITORIAL

A no-smoking policy

About a year ago the Wall Street Journal reported on a letter that was written in 1970 but had only recently surfaced. The correspondence, which was from a promotion firm working for a tobacco company, solicited the art department of a New York college to help design a cigarette package that would be "attractive to kids." The promoter apparently saw no duplicity in marketing a product to young people that contained the message "Caution: Cigarette smoking may be hazardous to your health." The potential designers were advised that "while this cigarette is geared to the youth market, no attempt (obvious) can be made to encourage persons under 21 to smoke. The package design should be geared to attract the youthful eye, not the ever-watchful eye of the federal government."

Thankfully, the tobacco industry's marketing methods have attracted the attention of the federal government – as well as state and local governments and organized medicine. Since 1970, smoking in public places has been legislatively restricted; tobacco taxes have increased; tobacco company personnel have become whistleblowers; and the tobacco industry has been held accountable for some of its actions. But even with all that progress, domestic cigarette consumption actually rose in 1995, an increase that has not occurred in more than a decade, according to the U.S. Department of Agriculture.

In addition, the rate of smoking by

high school seniors has recently risen, reported the Los Angeles Times.

The vice president of the American Heart Association expressed his frustration about the backslide, as reported by the LA Times: "Here we are, 30 years after the release of the first surgeon general's report, and we still have 42 million smokers in this country."

Medicine is keeping the pressure on, however. At the ISMS House of Delegates Annual Meeting, anti-tobacco resolutions were adopted. They call for ISMS to support smoking bans in all Illinois health care facilities and restaurants, a cigarette tax based on assessment of the public health care costs of smoking and participation in the multistate lawsuit against tobacco companies for the costs of treating Medicaid patients for tobacco-related illnesses.

Bills introduced in the General Assembly this session would ban the distribution of tobacco samples, would allow cities and counties to place stricter regulations on tobacco sales and would prohibit the sale of packs containing fewer than 20 cigarettes. ISMS supports these measures.

Last month, the AMA called on all health care professionals to divest any tobacco investments.

A spokesperson for the Tobacco Institute predicted in the LA Times that anti-smoking forces "are not going to get to their goal." Medicine, working with state and federal legislators, will eventually prove her wrong. ■

PRESIDENT'S LETTER

Medicine in the new millennium

Sandra F. Olson, MD



We can't let our patients end up as unwilling passengers on a ship steered by bureaucrats and insurance executives.

In his speech as outgoing president, Dr. Ray Hoffmann talked about the mantle of the office and his pride in having worn it. He mentioned that during his year, a thread or two became frayed, and repairs were needed, but he constantly felt the garment's warmth and comfort. Woven into that cloth are variations that represent the policies and positions that you, the members, develop and that the delegates act on at the Annual Meeting. Nevertheless, this mantle seems to fit each president, regardless of his or her shape or size.

You are the ones who determine who wears the garment. On April 21, I accepted it with humility, respect and a commitment to maintain your trust. In my inaugural speech, I announced the theme of my presidency: "Medicine 2001: A Professional Odyssey."

All of us are acutely aware of the rapid changes in the practice of medicine, with new forces swirling and shifting around us from day to day. How we harness, direct and control those forces will determine the medical care our patients receive. Many experts estimate this storm of change will continue for three to five years before stability prevails. That will take us to the year 2001.

We, as physicians, can't just passively allow the waves to toss us around. We have to fight to seize the helm and control the craft. It won't be easy because there are many shoals we must circumvent, and the waters around us are infested with sharks just waiting to gobble us up. You recognize the sharks – restrictions on physicians, the way we practice medicine and even the medications we prescribe; intensive and time-consuming administrative procedures, which by their very nature are adversarial to physicians and patients; and shifts in the continuity of patient care based on which plans are chosen by our patients' employers. We can't let our patients end up as unwilling passengers on a ship steered by bureaucrats, insurance company executives and anyone else who has

bought a ticket and wants a chance at the tiller.

What will the practice of medicine look like in 2001? We must decide this now and take the lead in influencing the landscape in which we'll live. We already have some glimpses, though. There will be increasing emphasis on maintaining wellness rather than just treating illness. Technology will be utilized to prevent disease and maintain function, not just to treat health failure. It is likely the entire population will be insured in some way, and entitlement programs such as Medicare and Medicaid will be privatized, at least in part. Social and epidemiological issues such as violence, drug abuse and the family will be more prominent in the comprehensive treatment of our patients.

How are we shaping our environment so that we can sail confidently toward 2001? To sharpen our focus, we and our patients will need constant education. Shakespeare said, "Ignorance is the curse of God; knowledge the wings wherewith we fly to heaven." Never before have we been so inundated with information that we must master. We must not only continuously expand our scientific foundation, but also deal with the regulatory, administrative, economic, political and social data that bombard us and profoundly influence our daily activities. Overriding every challenge is our ethics, which we must continue to hold sacred and use as our guide.

The Illinois State Medical Society is prepared to help us. ISMS has developed such resources as the Illinois Medical PSO to help us master our work with managed care organizations and support us in our business and administrative activities. The Society also helps by offering consulting services and CME programs, and working legislatively.

Everything ISMS stands for has been woven into the mantle Ray passed to me. I pledge to wear it faithfully, with honor and pride. And next year, when I pass it to Jane Jackman, your president-elect, I hope to have helped shape it in some way. ■

GUEST EDITORIAL

A future for medical associations?

By Prerna Mona Khanna, MD, PhD

For almost a century, an urgent mission was not addressed. That mission was to determine the future relevance and viability of medical associations by making decisions about professional unity and representation within those associations. And that mission is the subject of the Study of the Federation – the federation being all medical societies – which will be explored this June during the AMA annual meeting in Chicago.

This is the second consecutive AMA meeting at which the findings of the two-year study will have been discussed. The original report was submitted at the AMA's interim meeting last December in Washington, D.C. From there, it was sent back to a working group for revision.

The revision, with input from that December meeting, is ready for consideration. The new report recommends that specialty societies get proportional representation in the AMA House of Delegates to better level a playing field now based on geographical representation. It also asks that other organized special-interest groups of physicians who formerly may have felt disenfranchised – women, minorities and graduates of international medical colleges – be allowed to participate through more structured representation. The ultimate goal is to have the AMA governance more accurately reflect the diversity of the medical profession in hopes of better unifying that profession.

The genesis of the study was a call to action in response to marketplace turbulence in the delivery and financing of health care and an unsettling physician-association membership trend: Specialty society membership has risen as AMA membership has declined. That trend has suggested a fragmented, not unified, profession, just as physicians as a group have clearly needed to act rapidly and in unison.

In isolation, this trend may not have proved detrimental to patient advocacy efforts. But combined with the present competitive, regulatory, social, technological and economic challenges, fragmentation can only weaken the profession as a whole and dampen efforts at patient advocacy. So the Study of the Federation was born.

Anyone familiar with the AMA House may view as revolutionary these recommendations that could dramatically shift that body's power and influence. Yet shaping the governance of the AMA is consistent with a tradition that began in 1901 by the McCormack Committee, a group called to submit recommendations based on the medical profession of 1901.

The differences between physicians and the practice of medicine then and now are striking. At that time, physicians were a homogeneous bunch: almost exclusively born and trained in the United States, divided only by the two "specialties" of general practice and surgery, and destined for only one type of practice – solo.

Today's medical system is fortunate to embrace large numbers of women physicians (several Ivy League medical schools boasted a first-time women enrollment of more than 50 percent women just last year), a broad spectrum of racial and ethnic

diversity, and a blend of those trained abroad with the best that American medical training offers. Primary care, nonprimary care, subspecialties and superspecialties exist to treat the most elusive illnesses, and multiple variations on new and old models of integrated health care delivery systems are sprouting rapidly.

There is little wonder that the AMA's House of Delegates in its current configuration has ceased being relevant to more physicians. It doesn't even represent the current makeup of the profession, much less address the continuing rapid changes.

The Study of the Federation does not change the AMA's guiding mission, vision or objectives as documented in the association's recent strategic plan – seeking to foster a close relationship within the medical community to optimize the delivery of quality patient care. The study does seek to bring the AMA up-to-date. As Peter Drucker, the well-known management-organizational guru, once said, "The greatest danger in times of turbulence is not the turbulence; it is to act with yesterday's logic."

We can't predict if the efforts of the study will improve physicians' ability to act cohesively. But if we continue to muddle along on autopilot, functioning on yesterday's logic, our professional organizations will become ineffective patient advocates and less relevant as a whole.

And we all know what happens with irrelevancy. It is followed by obsolescence, then dissolution.



Dr. Khanna is an internist training in public health at Johns Hopkins University in Baltimore. She represents the AMA Resident Physician Section on the Study of the Federation Project Team and Consortium.



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Quotables

"Aetna's been able to get away with average [performing] networks. Sooner or later, having only average is going to kill you."

– **Robert Eicher**, a New York employee benefits consultant, on Aetna's merger with U.S. Healthcare and the growing trend of employers demanding efficiently run HMOs that don't sacrifice quality, Wall Street Journal

"The resolution was I would get no insurance and I would wait until I was 50 to see if I had symptoms. If I have no symptoms, they will give me a policy."

– **Theresa Morelli**, an attorney, on being denied disability insurance when the insurance company saw from her medical records that her father has Huntington's disease, USA Today

"Why do so few physicians ever fight back? This is a call to action. Tell the legislators, the lawyers and the administrators that the 'white coats are coming, the white coats are coming.' Passivity and politeness will no longer do. Physicians must take an active role in deciding their futures."

– **Sandra K. Makhorn, MD**, on how physicians should respond to the increasing regulation of medicine, Journal of the Medical Association of Georgia

"You have to scrape off the outer skin and then reshape the eyeball. It doesn't take a rocket scientist to see that's invasive surgery."

– **Patricia Caton Reardon, MD**, president of the Connecticut Society for Eye Physicians, on why ophthalmologists, not optometrists, should perform laser surgeries like photorefractive keratectomy, New York Times

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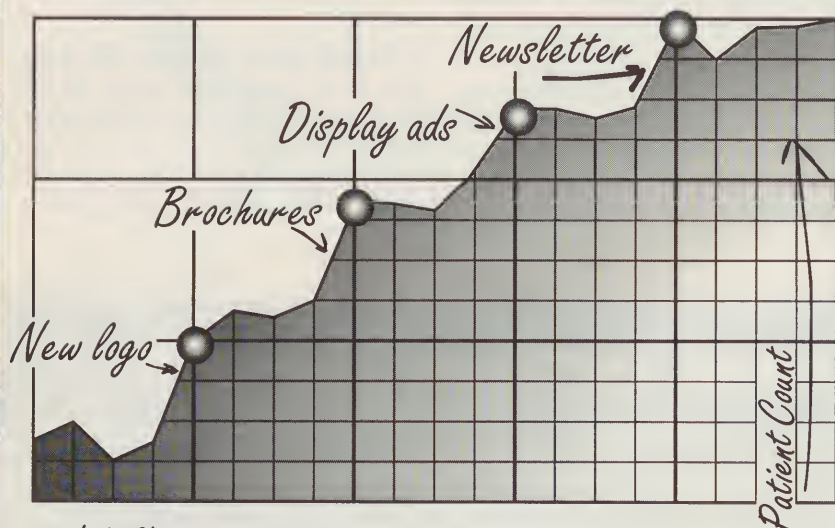
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Practice brochures enhance physician-patient relationship

Written materials expand communication and help reduce risk. BY RICK PASZKIET

Communication is vital to a healthy physician-patient relationship. One way physicians can enhance their communication with patients is by developing and using brochures and newsletters that describe their practices and procedures. Using such materials has the added benefit of minimizing the liability risks that can result from patient misunderstandings.

"With the complications brought on by managed care and the size of some medical practices, patients need to understand how their physician's practice functions," said Heather Doyle, a manager with Elmhurst Clinic, a multispecialty medical group practice. "A brochure is an easy way to give your patients necessary information. Our brochure, which is given to all new patients and is always available in the office reception area, covers a wide range of topics that address patient concerns. For us, though, the brochure's main purpose is to describe what our policies are and how we operate on a day-to-day basis."

The Elmhurst Clinic brochure covers various subjects, including the purpose and history of the practice, a list of physicians and their specialties and clinic locations. It also contains information on the scheduling and cancellation of appointments, confidentiality and the availability of medical records.

"Our brochure focuses on the basics, such as office hours and how new patients register at the clinic," Doyle said. "But we also give important information on our policy regarding prescription refills and how to notify a doctor in an emergency situation. From a risk management standpoint, it's good for the practice to have something that we can place in a patient's hand as a reference guide. If a patient doesn't know our policy on payment for services, he or she can either call the clinic or look at the brochure."

Practice brochures serve a vital function, according to Gail Brinkmeier, manager of physician marketing at Elmhurst Memorial Hospital. They set down in writing a medical practice's ground rules.

"A practice brochure can never really replace the information and personal assistance provided by an office's staff," said Brinkmeier, who helps medical practices like the Elmhurst Clinic develop and produce practice brochures and newsletters. "But a brochure should be viewed by physicians as another value-added resource that serves patients. Remember that good patient communications can only strengthen a practice's risk management effort. A medical brochure helps physicians and their staff question, examine and then develop office policies in an organized and systematic manner."

Ideas for brochures can come from anyone who has contact with patients, said Bobbie Scotto, office manager for the Evanston-based pediatric medical practice of Howard S. Traisman, MD; Irwin Benuck, MD, PhD; Edward S. Traisman, MD; Teri A. Merens, MD; and Constance Blade, MD. The practice sought suggestions from its physicians, office staff and even laboratory technicians. "Our office has more than 10,000 patients, and we needed to get as much input as possible," Scotto said. "We then were able to decide what subjects we needed to talk about, such as physician backgrounds, after-hours telephone calls, practice philosophy and insurance."

Medical insurance procedures, in fact, are highlighted in most practice brochures, since patients are often concerned about insurance billing and confused about their HMO and PPO participation.

"In our brochure, we have a section on billing, insurance and Medicare," said David Rothman, director of marketing and public relations for the Center

for Orthopedics in Belleville, where Donald I. Serot, MD, and Lawrence N. Stein, MD, practice. "This is an important area that should be included in any medical practice brochure. You don't have to go into any lengthy explanations. The brochure can just describe your office's payment policy and what is expected from the patient regarding insurance."

"Primarily, a practice brochure should be seen as a way to reach out and educate patients," Rothman continued. "You're opening the door to the communication process — this can only create good will between patients and physicians."

Physicians can communicate more regularly with patients through practice newsletters, which supplement brochures and can cover a variety of topics in greater detail. "We decided to produce and distribute a newsletter as a way to keep our patients informed about what's going on in the practice," said Melvin Gerbie, MD, an Ob/Gyn with the University Gynecologic Consultants, S.C., in Chicago. "Our first issue, which came out in March, announced the opening of a satellite office in Northbrook and the arrival of a new physician in our office. We also did

ISMIE breast cancer seminar to include mock trial, panel discussion

ISMIE is offering the seminar "Failure to Diagnose Breast Cancer: A Case Study" this month. One session will be held at the Arlington Park Hilton Hotel in Arlington Heights on May 15, and the other will be at the Collinsville Holiday Inn in Collinsville on May 16. Both sessions will run from 8 a.m. until noon.

The program is for physicians who deal with breast cancer diagnoses, including family physicians, general internists, general practitioners, Ob/Gyns, general surgeons and radiologists.

Through a mock trial and

panel discussion, the sessions will cover the most common allegations made in breast cancer litigation, clinical issues in screening and diagnostics, and risk management techniques that address diagnosis problems.

The cost is \$50 per person for ISMIE policyholders and their employees and \$100 for others. Physicians who haven't received a brochure with a registration form or who want more information should call ISMIE's risk management division at (312) 782-2749 or (800) 782-4767. ■

an article on insurance and managed care to help patients understand the differences between fee-for-service and managed care insurance plans. For our purpose, these subjects, because of their timeliness, were better suited for a newsletter format than a practice brochure. The newsletter gives us more flexibility."

Patient response has been favorable, Dr. Gerbie said. "Our patients were impressed with the newsletter and appreciated the information. I think it will be an excellent way to improve and strengthen the patient-doctor relationship, while also demonstrating our

commitment to patient care."

Newsletters can also be used to market a practice. "Newsletters are a way for physicians to expand their practices," said Brinkmeier. "They can discuss new medical procedures done in the office, describe specialty areas and make patients aware of the range of their services."

"But whether it's a newsletter or brochure, the purpose should always be the same — that is, meeting patients' expectations," Brinkmeier added.

To get samples of brochures or more information, call ISMIE's risk management division at (312) 782-2749 or (800) 782-4767. ■

MALPRACTICE ROUNDUP

Anesthesiologist acted within standard of care

A California court ruled last December that a physician who punctured a patient's dura mater when administering an epidural anesthetic was not negligent, according to the February 1996 issue of *Medical Malpractice Law & Strategy*. When he noticed the puncture, the physician terminated the epidural and administered general anesthetic, according to the case summary.

As a result of the puncture, which occurred during arthroscopic surgery, the 15-year-old patient underwent three years of treatment for severe lower back pain. She and her father claimed the anesthesiologist had failed to provide enough information about the epidural for them to give their informed consent. They also alleged that the way the physician performed the procedure did not meet the standard of care.

The jury, however, ruled for the defendant, who claimed the father interrupted him when he tried to give complete information during a pre-anesthetic conference. He also said that needle slippage is a known risk of epidural anesthetic, according to the story. ■

ISMS president prepares for medicine's 'professional odyssey'

Influencing medical evolution will be a top priority.

BY JANICE ROSENBERG



Photo: Eric Hausman/Hand coloring: Julia Ryan

Even though her term as ISMS president is 1996-97, the year 2001 will be a turning point for Sandra F. Olson, MD. That's because she has borrowed from movie director Stanley Kubrick for the theme of her presidency – "Medicine 2001: A Professional Odyssey." Her theme reflects her belief that medical evolution will be inevitable over the next five years. "By 2001 many of the forces currently affecting doctors will be played out one way or another, and we will have come to some decisions about how we will be viewing medicine in this country," she said.

One constant will continue to be the physician-patient relationship, the cornerstone of medical practice. Dr. Olson's devotion to the practice of neurology

has led to long-term relationships with patients who have chronic conditions. Yet, over the past 27 years, she has also committed countless hours to organizations that connect physicians with their colleagues and represent them in the world.

That dedication was recognized on April 21 when Dr. Olson was installed as ISMS president during the Society's Annual Meeting in Oak Brook. In an interview at her office – near Northwestern Memorial Hospital, where she practices – Dr. Olson discussed her background and her plans to help ISMS influence medical evolution. "Physicians are losing control of medicine, and we don't think that is good," she said. "We have to work to keep the control we have and regain what we've lost."

Doctors rarely worried about outside forces intervening in their practices when Dr. Olson entered Northwestern University Medical School in 1959. Then Sandra Forbes, she had grown up in East Chicago, Ind., where a love of science and an interest in people led to her decision to become a physician.

"I was curious about people's problems and how to solve them," she said. "In high school I enjoyed science, and when I started taking premed courses, I liked everything. It was a natural pathway for me."

Dr. Olson graduated from Purdue University with a bachelor of science degree in premedical studies and the highest honors. Four of the five medical schools to which she applied accepted her, including Northwestern, her first choice. At the time the school admitted only four women to each year's class.

Her interest in neurology began in a neuroanatomy class during her first year at Northwestern. From then on, if a case had anything to do with neurology, she was fascinated.

After graduation, Dr. Olson took a rotating internship at Wesley Memorial Hospital, now a part of Northwestern Memorial Hospital. She continued there with a year's residency in internal medicine followed by a residency in neurology.

She stayed on past her residency, taking a one-year fellowship in electroencephalography with John R. Hughes, MD, PhD, now a professor of neurology and director of neurophysiology and the epilepsy clinic at the University of Illinois at Chicago. At that time the late Benjamin Boshes, MD, chaired the department of neurology and psychiatry at Northwestern. When Dr. Olson's fellowship ended in 1969, Dr. Boshes invited her to work in his practice.

"This is literally his office," Dr. Olson said of her consulting room with its view of Lake Michigan. "Some of this was his furniture. From the beginning, I was very pleased to be here. I worked part time clinically and part time reading EEGs with Dr. Hughes."

Also in 1969, Dr. Olson was appointed an attending physician at NMH and an instructor in neurology at the medical school. In the 1980s, she was designated an associate professor of clinical neurology at Northwestern. "Teaching is an ongoing responsibility," she said, adding that she teaches residents in the course of treating patients. Dr. Olson continues as an attending physician and associate professor at Northwestern.

"Staying in one place is comfortable," she said. "My only concern is that one may not get a broad view of how medicine is practiced in other parts of the country."

AS SHE ESTABLISHED her medical career, Dr. Olson married attorney Ronald W. Olson. In 1970 she took six weeks off from work for the birth of their son, and in 1972, she again took time off for the birth of their daughter.

While her children were small, Dr. Olson was able to curtail her working hours, which helped her balance her career and family. "I was very fortunate," she said. "I have a wonderful husband who has always been supportive and helpful. I've had outstanding help with my children. And my professional colleagues were also understanding."

As her children grew older, Dr. Olson began devoting some of the time she had reserved for family matters to what she called extracurricular activities. She became the first woman to assume leadership in a variety of medical arenas: first woman president of the Chicago Neurological Society, 1980-81; first

woman chief-of-staff at NMH, 1982-84; first woman president of the Chicago Medical Society, 1993-94; and now, first woman president of ISMS.

"Naturally I've thought about my being the first woman to do these things," Dr. Olson said. "I suppose being the first of anything is significant. But there are many other women who are very well-qualified. I see myself as the first from the pool of women who will be honored by being put up for these positions."

The accolades for Dr. Olson are still coming in. Last month she was presented with a merit award at a Northwestern University alumni awards banquet. She was honored for distinguishing herself in a way that brings credit to Northwestern.

Dr. Olson noted that not everyone is willing to commit personal time to organizational work. Like most people who make that commitment, though, she daydreams about what she would do if she had more free time: "I'd own a horse and ride as often as I liked. I'd have time to read and listen to music. I'd travel to places like the Inca ruins in South America. And I'd go to more Cubs games."

Dr. Olson would also like to spend more time with her husband, now a Cook County Circuit Court judge, and her children, Ron Jr., 26, who is a computer programmer in New York City, and Kirsten, 24, who is about to begin law school.

Instead, Dr. Olson continues to add medicine-related responsibilities to her already exhaustive to-do list. She is an NMH board member and actively involved in the American Academy of Neurology.

For now, though, Dr. Olson is focusing on her role as ISMS president. "I can do only one main activity at a time," she said. "I will be representing our members and doing what they want me to do as best I can."

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TWO PROJECTS of particular importance to Dr. Olson and her fellow society members are the Managed Care Patient Rights Act and the Illinois Medical Physician Services Organization, both developed by ISMS. Each addresses issues of patient care and supports physicians in the changing health care climate.

MCPRA is a bill that would establish ground rules for patients, payers and physicians. The Illinois Medical PSO will provide physicians with consulting services and support for network development; support for managed care operations through verification of enrollment, eligibility and benefits; assistance in practice management; and services related to practice operations.

Both initiatives will help physicians work effectively in a medical environment increasingly influenced by managed care systems, Dr. Olson said. "Some managed care ideas are very good – namely, maintaining and promoting wellness. But there are times when the managed care rules can be very frustrating and intrusive."

Under managed care, some patients may experience access problems, and physicians may lose some control over their patients' care, Dr. Olson said. In her own practice, she often spends precious time on the telephone with managed care providers to justify treatment plans. She and her fellow physicians are also distracted from patient care by concern about liability issues, she said.

"We're not going to go back to the way medicine was practiced 30 years ago," Dr. Olson said. "But we want to control distracting influences so that we can concentrate on our patients. We want to keep the physician-patient relationship going as a sacred trust." ■

1996 ISMS HOD Annual Meeting highlights

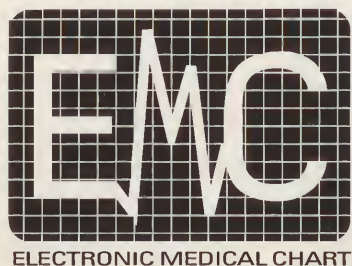


DELEGATES attending the 1996 ISMS House of Delegates Annual Meeting April 19 through April 21 in Oak Brook took action on the 95 resolutions submitted and elected new officers, members of the ISMS Board of Trustees and delegates and alternate delegates to the AMA. Changing places as ISMS president are Sandra Olson, MD (above), beginning her term, and Raymond Hoffmann, MD, completing his. On the House floor, Jerome Weiskopf, MD (top right), speaks out on a resolution. As resolutions are debated by the House, members of Reference Committee D (lower right) follow along on their reference committee reports.



RICHARD GELINE, MD (top), addresses Reference Committee B, which handled resolutions dealing with managed care issues. Presenting the report of the Reference Committee on Rules and Order of Business is James Bull, MD (above).

All photos by John McNulty



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IN REFERENCE COMMITTEE A, which discussed administrative issues, Biswamay Ray, MD (top), president of the Chicago Medical Society, shares his views. Patricia Merwick, MD (above), presents the report of Reference Committee E to the delegates. Her reference committee considered the implementation of the Illinois Medical Physician Services Organization.



AS CLAIR CALLAN, MD (above), president of the Lake County Medical Society and ISMS' 1996 second vice president, speaks to the delegates, former ISMS President Arvind Goyal, MD (left), and Albino Bismonte Jr., MD, wait their turn at the microphone. Reviewing a resolution during the House meeting is Armand Littman, MD (top left). At President's Night, Dr. Hoffmann (left) shows off his plaid to William Kobler, MD, as delegates express their support for Dr. Hoffmann. The group "Forever Plaid" performed that evening.



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Berlin decision

(Continued from page 1)

tive covenant was unenforceable. The contract's fee-splitting arrangement, which said Sarah Bush Lincoln would set all fees and have the exclusive right to bill for Dr. Berlin's services, was also an issue.

"This decision is in line with ISMS policy as adopted by the House of Delegates and is in line with the amicus curiae brief which we, along with several county medical societies and the AMA, filed in the court," ISMS General Counsel Saul Morse

said. "Essentially, the court held that there is nothing specifically permitting hospitals to employ physicians. Based on that, it felt compelled to follow the 60-year-old case law which prohibited corporations from practicing medicine."

ISMS policy states that if physicians are employed by entities composed of people not licensed to practice medicine in all its branches, and if those entities bill for services, the care provided may not be in patients' best interests. Exceptions are those stated in the Medical Corporation Act, the Professional Service Corporation Act, the Health Maintenance Organization Act and the Voluntary Health Service

Plan Act. Physicians practicing in bona-fide training programs or as independent contractors are also exceptions.

Although the appellate decision is significant, courts in other districts could rule differently, Morse said. "We won't know the final outcome until the state Supreme Court makes its decision." He also noted that a ruling to strike down an employment agreement does not prohibit hospitals from entering into management services agreements with physicians for those physicians' practices. "There are alternatives that would give hospitals less control and require physicians to be more active in their practices."

Supporting Dr. Berlin by signing on to the ISMS brief were the AMA, the Chicago Medical Society and the medical societies of Champaign, Lake, Livingston, Winnebago and DuPage counties. Other groups that filed a joint amicus brief were the Peoria Medical Society, the McLean Area Medical Association, the Downstate Physicians Alliance, the Illinois Heartland Physicians Association and the Independent Physicians Network.

"We are pleased about the decision," said Peoria Medical Society President Rodney Osborn, MD. "We feel it supports our concerns related to the corporate practice of medicine. The Medical Practice Act requires someone who practices medicine to be licensed to practice. And we're concerned about any entity that hires a physician when that entity isn't licensed to practice medicine."

In the 2-1 decision, Justice John McCullough dissented. "I agree with the health center's contention that there is not now a viable doctrine against the corporate practice of medicine," he wrote. "The contract entered into between the parties did not permit the health center to practice medicine. Nor did the contract compromise Dr. Berlin's practice of medicine."

Whether McCullough's thinking will prevail remains to be seen when the state's Supreme Court hears the case. The health center contends, as it has throughout the dispute, that contracts like the one it had with Dr. Berlin are necessary to protect a hospital's investment of recruitment resources.

"If the decision is affirmed by the Supreme Court, there will have to be a change in the way that hospitals structure their relationship with physicians," said Dr. Berlin's attorney, Cam Dobbins, of Dobbins, Fraker, Tenant, Joy and Perlstein in Champaign. ■

Mammograms advisable for women in their 40s

[RESTON, VA.] A study of seven major clinical trials suggests that women in their 40s should receive screening mammograms, according to findings released March 21 at an international conference in Falun, Sweden. The conference and the study were sponsored by the Swedish Cancer Society and the Swedish National Board of Health and Welfare. The results strongly support the recommendation of groups including the American College of Radiology, the American Medical Association, the American College of Obstetricians and Gynecologists, and the American Cancer Society, said an ACR news release.

The study included clinical trials conducted in five cities in Sweden, one city in Scotland and one in New York from 1976 to 1988. It revealed that breast cancer deaths dropped by 24 percent in women invited to have screening mammograms every two years compared to those who were not invited to undergo screening. "Not all of the women actually went. So, for those who had the mammograms, the decrease was even greater than 24 percent," said Stephen Feig, MD, an expert in screening mammography and a member of the ACR Task Force on Breast Cancer. Dr. Feig also noted that deaths decreased despite the fact that the women were not screened annually and that today's advanced mammography machines were not used in the trials. ■

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ISMS delegates

(Continued from page 1)

issued photo ID cards. It also calls for ISMS to "explore additional tracking mechanisms that would improve physician access to patients' advance directives at the time of treatment."

Those opposed to the resolution said interpreting abbreviated information about end-of-life decisions would be very difficult, since so many gray areas exist and patients may not understand their options. In addition, there would be no chance to amend or revoke an advance directive during the four-year validity of a driver's license.

In spite of the reference committee's recommendation to defeat the resolution, the House voted to adopt the original resolution.

GOOD SAMARITAN COVERAGE

Only positive testimony was heard on a resolution to extend Good Samaritan malpractice protection to physicians who volunteer at sporting or special events and mass gatherings. Physicians who volunteer in free clinics currently have such protection. As one delegate noted, doctors have had difficulty obtaining malpractice insurance to protect them when volunteering at such events.

The House adopted an amended resolution that calls for ISMS to support a liability exemption for physicians who provide free medical coverage during special events, to support the concept that such

efforts "be exempted under the Medical Practice Act in the same way that physician volunteers are presently exempted who work in free clinics" and to support legislation to effect the change.

WORKERS' COMPENSATION

The House passed amended versions of resolutions dealing with freedom of choice for workers' compensation patients and physician compensation in workers' comp cases.

The reference committee heard extensive, predominantly positive testimony on the freedom-of-choice resolution, which asks ISMS to reaffirm its position "in protecting the freedom of choice of the injured patient." It also calls for the Society to consider such freedom "a non-negotiable principle in any forthcoming legislation before the Illinois General Assembly." During the reference committee meeting, one physician noted that the possibility of limiting patients' choice of physician surfaced in negotiations on workers' comp legislation during the 1995 spring legislative session. The House adopted the resolution after it was amended to read "in protecting the freedom of choice of the injured patient with work-related injury."

The second workers' comp resolution directs ISMS to reaffirm its policy on the settlement of physicians' services and to seek implementation of its policy in any forthcoming state legislation. As the resolution notes, the House in 1987 directed the Society to support legislation that would permit physician liens in workers'

comp cases and in 1992 directed ISMS to support legislation requiring workers' comp carriers "to directly compensate physicians for medical services rendered at the time of or prior to any final settlement with the patient." The 1992 House action also specified that payment for services "shall be made within 60 days of receipt of the doctor's billing, and furthermore, payment made after 60 days should result in penalty payment of 1 percent per month to the physician." The resolution was adopted.

LEGALIZING DRUG SALES TO ADULTS

The extensive testimony heard on this complex issue touched on constitutionality, taxes, violence and drug trafficking. The resolution asks ISMS to study "the potential consequences of legalizing the sale of drugs to adults in a controlled fashion." One supporter noted that "what we're doing now is not working." Other supporters said legalizing drugs would stop the influx of drugs into the country and that taxes from drug sales could be used to fund drug rehabilitation programs.

Opponents, however, feared such action would "produce a group of non-productive people" and "be devastating to children [of drug users]." The reference committee recommended and the House approved referral to the Board of Trustees for report back to the House.

PUBLIC HEALTH

Six resolutions dealing with the major public health threats of smoking and

alcohol passed after little and mostly positive testimony this year.

The smoking-related resolutions ask ISMS to support or cause to be introduced legislation that would ban smoking in all health care facilities, call for the Society to develop legislation that would ban smoking in all Illinois restaurants, suggest that ISMS prohibit smoking at its Annual Meeting "in any public area in proximity to the meeting place" and ask the House to encourage the state legislature to assess a 50-cent-per-pack tax on cigarettes, with the money earmarked to help the state cover some health care costs related to smoking.

On the tax issue, a delegate presented a substitute resolution that was passed by the House. It recommends that ISMS "support the attorney general's consideration for joining in the multiple states' suits against tobacco companies for public expenditures for smoking-related illness." It also asks the Society to support assessments of the public health care costs of tobacco use and to apportion that cost to a cigarette tax.

One of the resolutions dealing with alcohol urges the Society to "advocate and encourage the development of legislation to prevent billboard alcohol advertisement." The other suggests that ISMS work toward state legislation that would lower the legal blood alcohol level for determining intoxication in drivers to .08 percent. That resolution is in line with the work of Gov. Jim Edgar and Secretary of State George Ryan to curb drunken driving in Illinois. ■

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Illinois Medicine

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General Assembly acts on health care bills

PAGE 2

Federal legislators speak out on health insurance reform bills

COMPROMISE: A congressional conference committee will try to reconcile U.S. House and Senate measures. BY RICK PASZKIET

[WASHINGTON] With the U.S. Senate's unanimous passage of the health insurance reform bill sponsored by Sens. Edward Kennedy (D-Mass.) and Nancy Kassebaum (R-Kan.), a congressional conference committee will have the difficult task of drafting a bill that's acceptable to both chambers of Congress. "The main provision of the Kassebaum-Kennedy bill, like the House bill, is that it prevents employees from losing their group health insurance if they change employers or lose their jobs," said U.S. Rep. J. Dennis Hastert (D-Ill.), chairman of the House Health Care Reform Working Group. "This provision basically increases the portability of private health insurance policies.

"In addition," he continued, "both the Senate and House bills contain a provision that limits to 12 months the period in which a new employee, even one with a pre-existing condition, can be excluded from an employer-sponsored health plan. This exclusion period, however, would be reduced by one month for each month that the worker was covered under a previous plan." But any break in the previous qualifying coverage could not exceed 30 days, according to the bills.

The measures also prohibit health plans and employers from basing coverage decisions on pre-existing conditions or health status. Under the Senate

bill, a condition would be considered pre-existing if it caused patients to seek "medical advice, care, diagnosis or treatment" in the six months prior to enrolling in a new plan, said a spokesperson for Hastert.

"I support the Kassebaum-Kennedy bill because it solves problems dealing with portability and pre-existing conditions," said U.S. Rep. Richard Durbin (R-Ill.). "Hardly a day goes by when I don't hear about the inequities associated with pre-existing conditions."

Durbin added that the Kassebaum-Kennedy bill, which has bipartisan support in the Senate, is most likely the type of legislation that will be signed into law. "Portability and pre-existing conditions need to be addressed now."

ISMS' health care reform principles support insurance portability and limitations on the use of

ISMS PRESIDENT

Sandra Olson, MD, receives a merit award at an April 13 Northwestern University alumni awards banquet in Chicago. Dr. Olson was honored for bringing credit to Northwestern by distinguishing herself in medicine.



Andrew Corrigan Halpern

pre-existing condition exclusions.

Hastert said he also supports the concept of small employers forming pools to purchase health insurance. "Today we have more than 40 million Americans who work but don't have any insurance. Insurance pools will encourage smaller companies, which now offer no health insurance, to give their workers coverage by forming buying pools and negotiating lower health rates from insurers."

The Senate bill creates a state-based system of "health plan purchasing cooperatives" – private, voluntary alliances intended to give small businesses and individuals greater pur-

chasing power in negotiating more favorable rates from insurance carriers and other health plan providers.

Despite the agreement on insurance reforms, there are major differences in the Senate and House bills that need to be worked out before a final bill goes to President Clinton. The Senate bill, for example, lacks two major provisions approved by the House in late March: tax deductions for medical savings accounts and a \$250,000 damages cap for pain and suffering in medical malpractice lawsuits. The two House provisions would be subject to presidential

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INSIDE

U.S. rep
discusses health
reform



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HCFA issues new guidelines for Medicare diagnosis codes

DEADLINE: Beginning July 1, carriers will deny claims submitted with truncated ICD-9-CM codes. BY KATHLEEN FURORE

[WASHINGTON] As of July 1, the U.S. Health Care Financing Administration will require Medicare carriers to deny as unprocessable, with no right to appeal, claims for physician services submitted with truncated diagnosis codes – that is, without the appropriate fourth- or fifth-level digit. The new guidelines implement 1988 OBRA, which requires as much specificity as possible in diagnostic coding. The fictitious diagnosis code XX000 will also be discontinued for physician services as of July 1, according to information from HCFA. To avoid denials and delays in claims processing, physicians should use coding that is as

specific as possible, following the 1996 edition of the International Classification of Diseases 9th Revision, Clinical Modification, 5th Edition, according to Kathy Shaheen, senior analyst in the Medicare Part B Provider Education Office.

If truncated coding is on an assigned claim, "it will be denied," Shaheen said. "And if it's a nonassigned claim, we will suspend the claim and send a development letter to the physician asking for information."

The assigned claims denied for truncated ICD-9 codes will not be paid through telephone review or reopenings, according to a letter from the Medi-

care Part B Technical Services Department. Physicians will be required to resubmit the services as new claims.

On a substantial number of claims, the coding does not represent the most detailed diagnosis possible, said Lisa Jones, an associate in Medicare's Technical Services Department in Marion. In March alone, almost 125,000 assigned and

nonassigned claims with truncated codes were submitted to the carrier, she said. For example, physicians commonly use just three digits when submitting diagnosis codes for diabetes mellitus, osteoarthritis and allied disorders, she said.

But beginning July 1, doctors must code diabetes mellitus claims with five digits, the fourth being 0 to 9 to indicate the type of disease – diabetes with ketoacidosis, for example – and the fifth being 0 through 3 to indicate such details as whether the disease is insulin or noninsulin dependent and juvenile or adult onset, Shaheen said.

It's also possible to make a

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General Assembly acts on health care bills

UPDATE: Measures address lawsuit against tobacco industry, Good Samaritan coverage. BY KATHLEEN FURORE

[SPRINGFIELD] In late April, a resolution was introduced in the Illinois Senate that urges Attorney General Jim Ryan to prompt Illinois to join seven other states in suing the tobacco industry to recover the cost of treating Medicaid recipients' tobacco-related diseases, according to a Senate news release. The measure was introduced at about the time the ISMS House of Delegates adopted a resolution asking the Society to "support the attorney general's consideration for joining in the multiple states' suits against tobacco companies for public expenditures for smoking-related illness."

One of the sponsors of S.R. 200 is Sen. Penny Severns (D-Decatur), who said, "Illinois' Medicaid expenditures on individuals with smoking-related illnesses total more than \$300 million annually. I strongly urge Attorney General Ryan to join other states in the legal action against tobacco companies, because the tobacco industry should take responsibility for the burden of the Medicaid costs that Illinois taxpayers now shoulder." A lead co-sponsor is Sen. Miguel del Valle (D-Chicago).

A spokesperson in Ryan's office said the resolution is being reviewed.

Liggett Group recently settled suits filed by Florida, Massachusetts, Mississippi, West Virginia and Louisiana.

The following bills saw action:

SARCOIDOSIS EDUCATION

ISMS-supported legislation requiring the Illinois Department of Public Health to inform the public about sarcoidosis was sent to Gov. Jim Edgar's office in early May. H.B. 2564 was sponsored by Rep. Mary Flowers (D-Chicago) after she learned one of her sarcoidosis-stricken constituents had trouble finding information about the illness. The cause of sarcoidosis is unknown, and it is often misdiagnosed as congestive heart failure, cirrhosis or obstructive pulmonary disease. "It is not a curable disease; it is a treatable disease. But one must know what one is treating first, and unfortunately a lot of people have died because of the misdiagnosis of the disease," she said.

ORGAN TRANSPLANT TASK FORCE EXTENSION

Legislators also sent to Edgar H.B. 2617, a bill that extends for three more years the statewide organ transplantation task force created in 1995; allows the public health director to add task force members, including at least two physicians, who have experience in the transplantation field; extends the final reporting deadline to Jan. 1, 1999; and authorizes the director to recommend the continuation of the task force after Jan. 1, 1999.

A THEATER TROOP, poets and politicians entertain youngsters at a Chicago Noodle Kidoodle toy store to kick off the "Look What I Can Do" campaign in early April. Sponsored by a council of the Illinois State Board of Education, the campaign will focus on the need for early intervention in developmental delays in young children.



John McNulty

"[Organ transplantation] is an area in health care that is unexplored, and for that reason, I think the task force needs to continue with its work," said H.B. 2617 sponsor and task force member Rep. David Wirsing (R-DeKalb). Another sponsor of the bill is Sen. J. Bradley Burzynski (R-Sycamore).

The task force will tackle issues including the high costs of transplants, the way in which organs are harvested and the criteria by which would-be recipients are prioritized, Wirsing said.

REPORTING ALCOHOL AND DRUG LEVELS

H.B. 3613, sponsored by Rep. David Winters (R-Rockford) and Burzynski, is on the governor's desk after being amended by the Senate and receiving concurrence by the House. The bill gives health care

workers in hospitals the option of reporting blood alcohol and drug test results to law enforcement agencies in the course of providing emergency medical treatment for patients injured in motor vehicle accidents. That reporting would not result in civil liability or professional discipline except in the case of willful or wanton misconduct. ISMS supports the measure.

ULTIMATE FIGHTING

Acting on a bill that is consistent with an ISMS House of Delegates position, the Senate passed a measure May 7 that bans ultimate fighting exhibitions in Illinois. The bill, H.B. 3271, is sponsored by Rep. James Meyer (R-Bolingbrook) and Sen. William Peterson (R-Prairie View) and is on the governor's desk. The

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U.S. rep discusses health reform

OUTLOOK: Illinois' John Porter makes case for 'pure markets with reasonable regulation' at ISMS Annual Meeting. BY HELENE BERLIN

[OAK BROOK] "There is perhaps no higher priority for the American people than quality health care, and if they don't get quality out of HMOs, they will reject them in a free market choice," said U.S. Rep. John Porter (R-Ill.) during a breakfast address April 20 before the ISMS House of Delegates. "I can't think of any issue that was more on people's minds during [my recent] campaign than access to our health care system."

On the subject of federal legislation, Porter said some form of the Kassebaum-Kennedy bill will be signed by the president, signaling a new phase of health care reform characterized by minimal government regulation to ensure fairness for consumers and providers.

Porter said he prefers the House reform bill, which in addition to establishing health insurance reforms, creates tax-free medical savings accounts and limits medical liability. However, he said he is content with the Kassebaum-Kennedy Senate version, which contains insurance reforms but not MSAs and liability limits. Differences in the bills will be worked out by a Senate-House conference committee.

Sponsored by Sens. Edward M. Kennedy (D-Mass.) and Nancy Kassebaum (R-Kan.), the Senate bill would curb pre-existing medical condition exclusions and enhance portability. And it attempts to give small businesses and individuals greater purchasing power in negotiating insurance rates.

Porter, who chairs the House Labor, Health & Human Services and Education Subcommittee, divided health care reform into four phases. Phase one began in 1993 when the Clinton administration advanced its health care proposals, which he characterized as "a highly bureaucratic system that most physicians saw as a real challenge to their independence and to their professional judgment. They saw themselves ending up as government employees."

In phase two, physicians worried about becoming HMO employees, Porter said. Profound marketplace changes happened quickly, "driven by the bottom line - the need of corporations in America to be economically competitive at home and across the world. The change has been very traumatic for health care providers across the board."

Reform moved into its third phase last year when Republicans tackled the budget by attempting to restrain an unsustainable rate of increase in Medicare and Medicaid, he said. Republican proposals would have of-

fered Medicare recipients the traditional program or a choice of HMOs, PPOs, MSAs or units without an insurance component that would have been formed by physicians, hospitals and other health care providers to compete for the business of Medicare-eligible individuals.

The Kassebaum-Kennedy bill and the government's attempt to regulate the

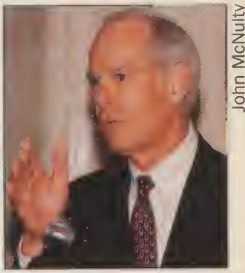
market represent phase four of health care reform, said Porter, who believes a regulated market system ensures fairness as well as competition.

"I would urge everyone in this room not to reject the market approach out of hand and not to look to government to solve all problems, but rather to ask government to make unregulated markets fair," Porter said.

He ended his remarks by stressing the importance of research. "We lead the world in biomedical research funding for the National Institutes of Health. The investment in developing a polio vaccine has paid for the entire cost of biomedical

research in our society through the entire 50 years of the NIH's history." Last year, Porter's subcommittee increased funding for the NIH by almost 6 percent.

Porter said the job of legislators is not to make "mindless cuts" in the budget but to base funding on which programs get results. "Once we make those judgments, biomedical research comes to the top."



Porter

John McNulty



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REPORT for Illinois Physicians

ALTERNATIVE CARE SETTINGS

An effective approach to shortening hospital lengths of stay, and therefore improving the cost effectiveness of health care services, is the use of alternative sites of service. Increasingly, many hospitalized patients can move into a less acute environment for greater portions of their care, and experience not only care of equal or potentially improved quality, but also high satisfaction and, an overall reduction in health care costs. Prime examples of such options are the use of skilled nursing facilities (SNFs) or home health care programs.

For both skilled nursing and home health, the number of facilities and programs continue to grow, and the range of services continues to expand. Services formerly available only in the acute care environment can now be easily arranged in these settings - including such examples as post-op care, infusion therapy, total parenteral nutrition, chemotherapy, telemetry and comprehensive rehabilitation programs. For example, the length of stay (LOS) for orthopedic joint procedures that traditionally were 7-10 days can now be decreased to less than half that many - by coordinating the post-op care and physical therapy in a skilled nursing facility, or at home. Patients formerly requiring continued hospital stay for IV therapy can often be discharged to have the same service delivered at home.

To realize the optimal value of these services, however, it is important that they be viewed as part of a program of effective discharge planning. The key features of any such program include:

- **early institution** - Most experts agree that discharge planning should begin within 24 hours of admission. For elective admissions however, discharge planning can even begin before admission - as in the case of an elective orthopedic procedure, where the patient can be oriented to a SNF preoperatively.
- **multidisciplinary approach** - The planning must include the attending physician, any consultants, social worker, case management staff if applicable, and the patient and family.
- **inclusion of all options** - A thorough knowledge of all available alternatives for care, such as home health etc., must be present and be applied to the discharge plan.

Given the expansion of services available in alternative sites, the potential applicability of this cost containment approach to a wide range of hospital diagnoses is evident.

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EDITORIAL

Arresting violence

It's easy to become hardened to violence. We're assaulted by it nearly every day through movies, books, TV, newspapers – and, unfortunately, real life. For children, guns may become accessories as popular as backpacks if the trend continues. Gunfire is now the second-leading cause of death among Americans between the ages of 10 and 19, according to a Children's Defense Fund study reported in the New York Times. The only higher cause of death is accidents, primarily involving vehicles.

Other grim statistics from the study: In 1993, an American between 10 and 19 died every 92 minutes from gunfire. For young people under 20, death by guns increased 7 percent in 1993. Of those 5,751 deaths, 3,661 were homicides, 1,460 were suicides, 526 were accidents, and 104 were from unknown causes. Breaking down the figures by age reveals that 116 victims were younger than 5; 141 were between 5 and 9; 700 were between 10 and 14; and 4,794 were between 15 and 19.

A recent television news magazine featured interviews of children in prison for doing the unthinkable – killing other kids. What was remarkable, beyond the obvious, was the apathy and hopelessness expressed by those children who had committed murder.

The feature story in this issue highlights a program on violence prevention presented at the ISMS Alliance Annual

Meeting in April. The speaker, John May, MD, has seen the results of violence up close. At Cook County Hospital, where he's a voluntary attending physician, the incidence of multiple gunshot wounds has increased from one in 20 in 1982 to one in four today. He cited a Harris Poll in which 59 percent of sixth- through 11th-graders said if they wanted a handgun, they could get one.

There is cause for hope, though, because violence in the United States is out of proportion with violence in the rest of the world, Dr. May said. If it isn't innate human behavior, it must be reversible.

Toward that end, the ISMS Alliance is continuing its Anti-Violence Initiative, which has already produced a program, a video and an educational kit on domestic violence. In addition, ISMS policy supports the right of counties or municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms and ammunition. It also opposes ready access to handguns unless the purchaser is obviously responsible and urges strict enforcement of current federal, state and city laws that govern access. Finally, it states that all offenders should receive maximum penalties from the courts and the legislature.

Violence has become a public health crisis, and physicians should get involved in arresting it. ■

PRESIDENT'S LETTER

Here and there

Sandra F. Olson, MD



Members of organized medicine in these states are grappling with the same issues as we are.

One of the benefits of being president of ISMS is being invited to other state societies' annual meetings. My husband and I have just returned from Michigan and Ohio. We were welcomed with warm hospitality, and I was able to view the deliberations of their reference committees and houses of delegates. I want to share my observations with you, as I found their proceedings both interesting and enlightening.

Members of organized medicine in these states are grappling with the same issues as we are. They have like problems and concerns, and the solutions proposed are often similar, with a little local flavor. This is not surprising, because the major problems are universal.

Managed care and its effects on patients and physicians took center stage in both states, as you might expect. There was clear and strong opposition to gag rules. Physicians debated incentives and reimbursement for care (or noncare), making interesting observations on HMOs and fee-for-service plans. They discussed such related issues as credentialing, deselection, utilization, quality review, freedom contracts for both patients and doctors and the publication of practice guidelines.

The corporate practice of medicine also is becoming a greater issue. Both meetings addressed the subject of who may practice medicine in their state. Telemedicine – with doctors from out-of-state diagnosing or recommending treatment for patients, along with prescriptions written by out-of-state physicians – raises licensure problems similar to the concerns we raised.

Each society conducted a forum on the proposed restructuring of the AMA. There was apparently little controversy in either state, and neither made any specific recommendations that I heard.

At each meeting, delegates considered resolutions to study a single-payer system. I was impressed by the sincerity of their sponsors. The authors of the resolutions had carefully researched the issue,

and especially in Ohio, the delegate presented a very impassioned argument for passage. The familiar reasons for and against were recapitulated in committee discussion, and the sentiment of the group was clearly not positive for this type of health care delivery. The physician in Ohio stated that he might even lose his job in an HMO for his public statement. But he was willing to stand up and be counted, and while he didn't seem to convince anyone, he gained insurmountable respect, not just for his passion, but most of all for his sincerity, integrity and fortitude.

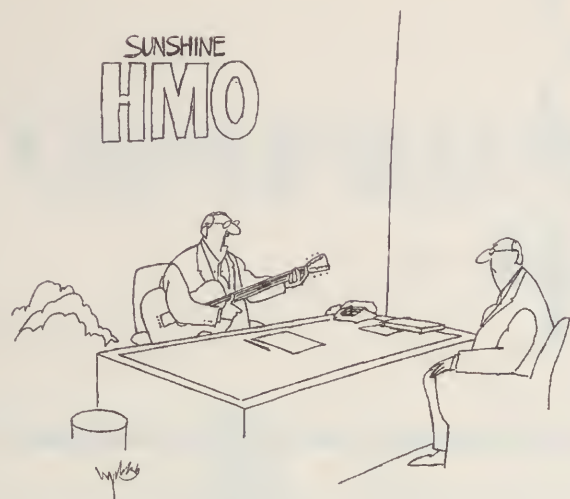
Another topic that drew a generally favorable response was medical savings accounts. Not everyone supported their inclusion in health care reform, but because of the discussions, the delegates had a chance to debate the mechanics and financial effects of MSAs.

Michigan passed a resolution to form an MSO with a different structure than the Illinois Medical Physician Services Organization. It also rejected forming an HMO for reasons similar to ISMS'.

Public health issues such as HIV testing, billboard advertising of alcohol, ultimate fighting, tobacco use and domestic violence generally received similar treatment in both meetings as in our House a month ago.

It's obvious that physicians have common concerns and that our thinking and the consensus for solutions are not dissimilar. How we answer these questions and work together locally and across the country through the AMA will determine the ultimate state of medical care in our country in the year 2001.

This overview of our neighbors' deliberations gives you an idea about how our colleagues in two states are thinking and dealing with the same problems. Many of these topics, indeed, probably most, will go to the AMA as resolutions and will elicit the broad input of delegations across the country. Stay tuned for the results. I think you'll find them interesting. ■



"We're prepared to buy your practice - for a song."

GUEST EDITORIAL

The cost of smoking

By Susan Gilbert McGuire

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It's a cold Chicago afternoon. The wind is blustering off Lake Michigan with blizzard gusto. My shopping done, I button my jacket and walk out the door of the bookstore. A man of about 60 and just a bit grizzled leans on a metal walker by the doorway. In anticipation of his request, I reach for my wallet to pull out a dollar. A peculiar confidence tightens his features, and to my bewilderment, he reaches into his pocket. He takes out a pack of cigarettes as he waits.

My hand stops. He senses my hesitation and quickly exhales smoke that disappears in the frigid air. "Lady, I just need a couple bucks for a meal."

I shake my head no. I drop my wallet back in my purse.

"Lady," he pleads, realizing that I've changed my mind.

I stride past him to my car. "Lady..."

I'm flaming mad, but I also feel guilty for not giving him the dollar. I want to turn around and tell him why I did not give it to him. I want to tell him I'm normally generous. But, for me, that isn't the issue.

The issue is the cigarette. If he has money for cigarettes, he has money for food. If I give him a dollar, I'm enabling him to continue buying cigarettes. Therefore, I would be supporting the tobacco industry.

That I will not do. Cigarettes kill. Cigarettes killed my grandfather, who died from lung cancer. Cigarettes killed my first boyfriend, who fell asleep smoking and died of smoke inhalation in a fire that burned his body beyond recognition. Cigarettes are killing my husband, who has lung cancer.

If I confront the man with my vehement thoughts, I will look like one of those crazed people who have lived in the city a bit too long. So my thoughts simmer in me as I start my car. I hit rush hour traffic, and I realize I'll be late getting home to my husband.

Today isn't a good day for him. It is the third day after chemotherapy. His blood counts, affected by the chemotherapy drugs, are low, and that makes breathing with his one remaining lung even more difficult.

My husband doesn't smoke cigarettes.

He quit six years ago. Four years before his cancer diagnosis but years too late to save him. The surgeries and therapies have lengthened his life, but the therapies also nearly killed him. Now the cancer is in his bones.

When I see him struggle to breathe or to eat or to climb stairs, I think of the tobacco industry, complete with corporate presidents and middle managers, office clerks and farmers. Not just the big bad wolf, I tell myself, but men and women working just like anywhere else. Most people must have jobs to support themselves.

Do the tobacco growers and middle managers and secretaries believe, as their corporate presidents proclaimed with a great show of innocence before Congress, that cigarettes don't cause life-threatening illnesses? Or do they rationalize their positions within the industry and make a morality call: "I must feed my family. I can't worry about anonymous victims"?

If as many people died in plane crashes annually as they do in smoking-related deaths, the government would spend millions investigating and correcting the problems. Instead the votes from a sympathetic Congress give tobacco farms and companies the protection to thrive, as though they were a rare species near extinction.

If we are serious about ending the death grip the tobacco industry has on our society, we must create new rules, new laws. If the tobacco industry has enslaved some members of Congress, then those of us who know, those of us who see or have heard about the terrors wrought on families by cigarettes, must vote against them.

What else can we do? Here is a start, a place where I have begun:

I don't allow anyone to smoke in my house, not in my presence.

I don't buy magazines with cigarette advertising. I cancel subscriptions.

I talk about the horrors I've seen cigarettes ravage on those I love.

I don't give money to beggars who smoke cigarettes.

I arrive home. As I open the front door, I hear my husband coughing and wheezing uncontrollably upstairs. My guilt about not giving the dollar to the beggar is gone. ■

Quotables

"It's an attempt to eliminate the boundary between work-related and nonwork-related health coverage."

— **Bob Russell**, Chicago risk management consultant, on the formation of Third Coast Insurance Co., which will combine traditional health insurance coverage and workers' compensation insurance, Chicago Sun-Times

"Our patients regrettably view us as a group increasingly concerned with our own material rewards. Charitable giving of time and assets by physicians will help counteract this impression."

— **Marcia J. S. Richards, MD**, president of the State Medical Society of Wisconsin, Wisconsin Medical Journal

"Medical schools have traditionally done a lousy job of teaching about this disease [chemical addiction]. That's beginning to change, but it's changing very slowly."

— **Thomas L. Haynes, MD**, a former addict and current medical director of West Michigan Addiction Consultants in Grand Rapids, Mich., Michigan Medicine

"Whether somebody accepts or rejects the prize is up to them."

— **Richard Storrs**, an advertising salesperson with PIC-TV Inc., on the awarding of melatonin as a gift to contestants on "Jeopardy," Wall Street Journal

"Have we lost our backbone and sense of history, and are we now going to follow the allure of marketing and dollar signs and fall into a delivery system of fast foods, quick fixes, discount medicine and Madison Avenue hype?"

— **Alex E. Finkbeiner, MD**, on his receipt in the mail of "surgery bucks" coupons redeemable at a local surgery center, Journal of the Arkansas Medical Society

"It's a victory for all people who suffer from psychiatric illness. These people are not morally weak, defective or simply lazy. They suffer from genuine illnesses."

— **Herbert Pardes, MD**, dean of the College of Physicians and Surgeons at Columbia University, on Senate passage of the Kassebaum-Kennedy bill with its provision establishing more parity between mental health insurance coverage and other medical coverage, Chicago Tribune

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ISMIE Update

Understanding premium rates

Data and trends show what's needed to cover losses. BY LYNN KOSLOWSKY

The process by which insurance premium rates are figured may seem a little like sausage-making to some – they don't really want to know what goes into it. But an April 19 presentation at the ISMS House of Delegates Annual Meeting in Oak Brook dispelled some of the mystery. To determine rates, actuaries analyze historical loss data and trends and project the necessary financial resources to cover future losses, said speaker Alfred Clementi, MD, chairman of the ISMIS Board of Directors. "Simply speaking, the process depends on two factors – claims frequency, which is the number of claims reported, and claims severity, the amount paid per claim," he said.

"It's an industry practice to determine a 'base physician,' and ISMIE follows that practice," Dr. Clementi explained. This physician typically represents a low-risk specialty and a geographic area in which the greatest number of policyholders practice. The example he used in his presentation was a physician in family practice in Cook County with policy limits of \$500,000 per person and \$1.5 million aggregate, and with a mature claims-made policy.

Dr. Clementi defined a claims-made policy as "coverage for claims reported during the policy year and resulting from professional services given on or after the first date of coverage. One of the benefits to doctors is that the pricing is based on claims that may be reported for each particular year of coverage. During the first year, for instance, the probability is low that services rendered will result in a claim that's reported that same year." But in the second year, he added, the premium must cover claims that will occur and be reported that year as well as claims that occurred in the first year but will be reported in the second. ISMIE policyholders reach a "mature" rate in the seventh year, when the cost and number of claims reported level off, he said.

For ISMIE, two actuarial firms and in-house actuarial staff

review data and trends and analyze historical losses to determine the number of expected claims, the outcome of those claims and the indemnity and defense expenses that will result from them, Dr. Clementi explained.

"Let's assume that ISMIE is a company with 1,000 policyholders in different specialties – some high risk, some low risk – and we expect 130 claims to be reported," he said. "Twenty-nine claims would eventually close with payment to the plaintiff and defense costs; 89 would close with only defense costs; and 12 would be closed with no indemnity or expenditure."

If the average amount paid per claim with indemnity is assumed to be \$285,000, multiplying that figure by 29 claims would equal \$8.27 million, Dr. Clementi said. Multiplying the assumed average defense expense of \$26,000 by 118 claims – the 29 claims plus the 89 that closed with only defense costs – would total \$3.07 million.

Adding those two totals and dividing by the number of policyholders provides a "pure premium rate," he said. In the example, that would be \$11,333.

The next step is to apply a factor for the "time value of money." That factor, .77, is determined by actuaries and takes into account the projected losses and how and when they'll be paid. It reflects the effect of investment income earned by premiums before losses are paid, Dr. Clementi said. Multiplying .77 by the pure premium rate in the example equals \$8,726.

The last step is factoring in the administrative costs for underwriting and claims handling at 10 percent, costs related to tail exposure at 5 percent and a reserve for contingencies at 5 percent. Multiplying \$8,726 by 20 percent equals \$1,745, which would be added to \$8,726 for a total of \$10,471 in the example. "That provides the base premium rate, the point every policyholder starts from," Dr. Clementi said.

Of course, not every policy-

holder is identical to the base physician, he noted. "So, adjustments are made to the base physician rate depending on the level of risk in a specialty, the extent of risk in the geographic area where the practice is located, the limits of the policy and the stage in the claims-made coverage.

"To determine the rate for, say, orthopedic surgery, we start with the number of losses experienced by policyholders in that specialty, then compare them with national data," Dr. Clementi said. "Then we compare the data with ISMIE data from last year."

The data is used to project future losses for that specialty and territory, he explained. "After reviewing the data and claims frequency and severity,

changes may be recommended that can affect rates. For instance, nationally and in Illinois, anesthesiologists received a discount several years ago because they had fewer losses, and anesthesiologists insured by ISMIE are scheduled for another discount in the upcoming policy year." He attributed that progress to anesthesiologists' strict monitoring and aggressive risk management procedures.

Regardless of policyholders' specialty or geographic area of practice, ISMIE rewards loss-free experience through its Loss-Free Discount Program. Specifically, policyholders who have gone without a paid loss for three consecutive calendar years receive a 3 percent credit on their base premium, Dr. Clementi said. For each additional year without a paid loss, another 1 percent is discounted, up to a maximum of 10 percent for 10 years or more of loss-free experience. "Physicians who've had claims filed against them

don't lose the discount, but those who've had losses do."

For the upcoming policy year, no specialties will receive premium increases, Dr. Clementi said. In fact, gynecological surgeons and hand surgeons, as well as anesthesiologists, will see premium decreases. As in the case of anesthesiologists, strong risk management procedures can alleviate a loss trend, he said.

"The Illinois Department of Insurance requires insurers to keep a surplus sufficient to cover the risk that loss projections are wrong," Dr. Clementi said. "Insurers, including ISMIE, have to keep money in reserve for losses that are out there. For ISMIE, there are about 5,000 open cases, and some [will be] losers." Anticipating that risk management and tort reform will improve the frequency and severity of losses, ISMIE intends to keep its surplus at the minimum required level, which will also keep policyholders' rates as low as possible, he said. ■

ISMIE is offering premium financing option

Policyholders can make a down payment and pay 11 equal installments.

BY LYNN KOSLOWSKY

As part of its expanding menu of products and services, ISMIE is offering the option of premium financing to physician and group policyholders for the 1996-97 policy year. The option allows policyholders to make a down payment of 8 percent followed by 11 equal monthly payments with interest less than the prime rate, according to Harold Jensen, MD, chairman of the ISMIE Board of Governors.

"For many physicians and groups, paying premiums monthly works out better than making quarterly payments with no finance charge, which was the only payment arrangement ISMIE previously offered," Dr. Jensen said. "They may have had to build up their reserves to make the quarterly payments. The monthly option will help free policyholders' existing credit lines and maximize their cash flow." Physicians who want

to continue paying their premiums quarterly, however, may still do so.

The financing alternative will be administered by Cananwill Inc., one of the oldest and largest financing enterprises in the United States, according to an ISMIE analyst. Cananwill is affiliated with Aon, a company with which ISMIE already has a working relationship. Aon's professional brokers are authorized to sell ISMIE products, and the Aon Alliance for Healthcare handles claims and underwriting for ISMIE's capitation stop-loss policies.

"Before we chose Cananwill, we looked at a couple of companies," the ISMIE analyst said. "Cananwill did a trial run on an account, quoting on it according to different scenarios. They demonstrated how consistent and responsive they could be."

Dr. Jensen explained how the financing will work: "Poly-

holders who are interested in financing will come to ISMIE, and ISMIE will work with Cananwill to get a quote. If the quote is acceptable, policyholders will get a financial contract that's very much like a contract for financing a vehicle. Policyholders will make their payments to Cananwill."

Other new products and services offered by ISMIE include increased policy limits for corporations and clinics, capitation stop-loss coverage and business practice liability insurance.

"We'll continue working to meet our policyholders' changing needs while providing consistent Physician-First Service," Dr. Jensen said. "The financing option increases flexibility for physicians."

For more information about premium financing, policyholders may call the underwriting division at (312) 782-2749 or (800) 581-4767. ■

CONFRONTING VIOLENCE

Physician addresses a 'public health emergency.'

BY KATHLEEN FURORE

Arnold Schwarzenegger totes an Uzi machine gun and a stick of dynamite and becomes a hero. "This is our culture in America, where we glamorize violence and celebrate it. But there is very little to celebrate about a patient with multiple gunshot wounds in the Cook County [Hospital] trauma unit," said John May, MD, in an April 19 presentation during the Illinois State Medical Society Alliance's Annual Convention in Oak Brook. Dr. May is the assistant medical director for the Washington, D.C., Department of Corrections, a service physician for Cermak Health Services of Cook County at the Cook County Department of Corrections in Chicago and a voluntary attending physician at Cook County Hospital. His speech kicked off another year of the Alliance's anti-violence campaign.

Using a backdrop of sobering homicide data and slides of still-bloody gunshot victims, Dr. May said: "We're going to look at violence as a public health issue, framing it as we have other major epidemics in our country that have taken a tremendous toll on our health and well-being. We need to focus on individual behaviors that contribute to illness or injury [from violence] and on the contributing environment."

Citing violence as "our new public health emergency that demands our attention," Dr. May said deaths from gunshot wounds are expected to exceed those from car accidents by the year 2,003.

Creative approaches to prevention and increased support services for those at risk can help stem the tide of firearm injury and death, Dr. May said. The Rise High Projects group he founded, for example, develops preventive items such as billboard, classroom and public transport posters to educate young people about the dangers of guns. Among the messages: "Let Pride Be Your Weapon" and "Peace - Live It or Rest in It."

Such anti-violence groups have a big job ahead of them, according to some statistics Dr. May cited: One in every four teen-age deaths is attributed to gun violence; one in 24 young black men will die from homicide; and male teens are more likely to die from gunshot wounds than from all natural diseases combined.

"The United States is way out of proportion to the rest of the world when it comes to violence," Dr. May said. "What this tells me is that violence is not necessarily innate human behavior. That is both a reason for hope and a cause for alarm. I don't think our children are more violent today than they were 30 or 40 years ago. And I don't think a magic cloud of dust has moved across our country raining drops of evil. But there are so many guns around that a simple fight is no longer just a [simple fight]. It used to be with fists or sometimes even with knives, but now you've got to be packing your .45 or .22 or 9 mm [gun]."

The prevalence of semiautomatic weapons has also increased mortality and complications like spinal cord injuries for gunshot victims. "In 1982, one in 20 [gunshot victims] at Cook County had multiple gunshot wounds. Now it's one in four because of semiautomatic weapons," Dr. May said.

He also said results from surveys of children are "very telling." In one recent Harris Poll, for example, 59 percent of some 2,500 children in sixth through 11th grades said they could get a handgun if they wanted one. Fifteen percent said they had carried a gun in the last 30 days. And one-third said it was likely that their



Dr. May

chances of living "to a ripe old age" would be cut short because of guns, according to Dr. May.

Suicide statistics underscore that despair. "Extraordinarily high numbers of children have considered or attempted suicide," Dr. May said. And they are more likely to succeed with a gun than with any other means.

Dr. May also disputed the notion that people need guns to protect themselves. "Owning a gun really increases their risk rather than protects them," Dr. May said. "Of the 23,000 U.S. homicides in 1993, only 811, or 3.5 percent, were classified as justifiable in self-defense. And one-half of those were [committed] by law enforcement officers."

Dr. May said a study published in the New England Journal of Medicine showed the chance of homicide to be three times more likely in homes with guns than in those without and the chance of a victim's being a family member, not an intruder, to be 43 times more likely in homes with guns. "As practitioners, as health care advisers, we ought to let [our patients] know what the data tells us."

And those patients want to know, he said. In a study conducted at Cook County Hospital, treating physicians talked about smoking, drinking, safe sex, seat belts, drugs and firearms with young men presenting in the emergency department for problems unrelated to violence. The issues they later remembered and considered most important? "Guns, followed by safe sex," Dr. May said. And 80 percent of the respondents said they believed it was important for doctors to talk with them about guns, he noted.

But Dr. May has heard disturbing tales of what providers have said to gunshot victims they treat - "Why don't you grow up?" "They sure did a good job on you" and "You gangbangers deserve everything you get," his Cook County Jail patients have recounted.

"The words we use struck me," Dr. May said. "If alcoholics are admitted for pneumonia, we have social workers come by before they're discharged. But if they're [victims with] gunshot wounds, we patch them up and send them out the door. We're missing the opportunity for prevention."

To close his presentation, Dr. May showed anti-violence public service announcements that have run on HBO and MTV. The audience was left with the image of a baby's dishes falling in slow motion from a high chair after a child sits on his bed and fires a gun.

"We must make the environment safe so that our kids can be kids," Dr. May concluded. ■

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HCFA issues

(Continued from page 1)

mistake by adding 0 to a three-digit code that has no fourth or fifth digit. For example, the ICD-9-CM code 185 for malignant neoplasm of the prostate doesn't need a zero, Jones said.

Shaheen said that although most Medicare carriers use an ICD-9-CM coding book published by the Practice Management Information Corp., other versions likely contain the same information. The AMA, Medicode Publications, St. Anthony's Hospital and McGraw Hill all publish ICD-9-CM code books. "The information is all from the same source even though the books are published by different entities. So it should all be the same, although there might be differences in the format of the books."

Physicians should, however, use the most current version of the coding manual to avoid denials of and delays in processing claims, Shaheen said. "They shouldn't be using a 1993 edition." The manuals are revised annually, according to an ISMS analyst.

ISMS is encouraging HCFA to phase in the rejection of claims for truncated codes, the analyst said. Nevertheless, physicians should be prepared to follow the new guidelines by July 1. Members who have questions may call ISMS' health care finance division at (312) 782-1654 or (800) 782-ISMS.

All of the 1996 coding manuals are available at reduced rates to AMA members. To order, phone (800) 621-8335. ■

Federal legislators

(Continued from page 1)

veto because the president has said MSAs primarily benefit healthy, wealthy individuals and could lead to increased premiums for families with conventional health insurance, and he opposed medical malpractice reform last year.

A controversial aspect of the Kassebaum-Kennedy bill is the provision that mental and physical health problems be covered with equal levels of benefits. "Many employers fear that this provision will cause their health insurance costs to dramatically increase," Hastert said. "I already have seen some statistics that indicate health costs for employers could increase by almost 12 percent with this provision. It could actually decrease the availability of mental health insurance for workers. Employers will just drop mental health coverage from their plans."

The goal of the House bill is "to find

ways to make health care more accessible as well as more affordable," Hastert said. "MSAs would be available to people to make tax-free contributions to accounts that could then be used to help pay their medical bills. Employers also could set up MSAs to replace basic coverage. Under the bill, employers could annually contribute to employees' MSAs up to \$2,000 for individual coverage and \$4,000 for family. And, of course, employees would not be taxed on employers' contributions." To supplement the savings accounts, employers would purchase high-deductible, catastrophic coverage for their employees.

At the recent ISMS Annual Meeting, delegates adopted a resolution that encourages the Society's Board of Trustees and the AMA to continue developing education programs regarding MSAs.

Capping medical malpractice awards would help foster lower health care costs, Hastert said. "With a cap on malpractice

awards, the cost of malpractice insurance goes down, and then the costs of delivering a baby, [for example] will also go down."

Durbin had a different view: "Malpractice caps and MSAs are provisions designed for special interests, such as the Golden Rule Insurance Co. [a major supplier of the MSA policies already in use], and therefore should not be included in this bill." He added that those issues should be debated separately.

But what's most important is for Congress to pass a bill that has the support of the president, Durbin said. "The White House has indicated it endorses the Kassebaum-Kennedy bill."

Despite the differences between the two measures, Hastert said he believes Congress will develop a bill acceptable to President Clinton. "This [Kassebaum-Kennedy] bill is an important first step to health care reform. Although it's narrow in scope, this legislation shows our commitment to solving important health care problems." ■

General Assembly

(Continued from page 2)

HOD resolution said ISMS should "prepare and cause to be introduced in the Illinois General Assembly, legislation that would prohibit ultimate fighting and ultimate fighting championship bouts in Illinois."

GOOD SAMARITAN COVERAGE

Two bills dealing with Good Samaritan protection have progressed. On May 7,

the Senate passed H.B. 3618, which awaits the governor's consideration. The measure puts into one act Good Samaritan immunity provisions contained in other legislation governing various professions and activities. Winters and Burzynski sponsored the bill. In addition, the Senate Public Health Committee passed a bill that provides immunity from liability for civil damages to volunteers who transport people to or from a health care facility or service unless those volunteers' acts or omissions constitute

willful or wanton misconduct. Sponsors of H.B. 2691 are Rep. Carolyn Krause (R-Mt. Prospect) and Sen. Dave Syverson (R-Rockford).

H.B. 2691 is consistent with an ISMS HOD position that the Society "seek to have legislation introduced in the General Assembly that would extend the state's Good Samaritan Act so as to provide protection from civil liability to unpaid volunteers acting appropriately, without malice, engaged in the transport of patients to facilitate health care." ■

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Illinois Medicine

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NEW ORGANIZATION:
Reference committee
presentation precedes
House action.

BY KATHLEEN FUREORE

[OAK BROOK] Saying the time has come to "get down to business," Edward Fesco, MD, ISMS Second District trustee, discussed the Illinois Medical Physician Services Organization during a reference committee meeting April 19 at the Society's House of Delegates Annual Meeting. Dr. Fesco serves as chairman of the PSO Board, which will oversee the operation of the new organization. His presentation preceded a House of Delegates vote to reaffirm the creation of the PSO.

"I think you'll quickly see the enormous practical value this new organization holds for each and every one of us and how these services can be used to preserve and enhance physicians' clinical autonomy in the new, managed care marketplace," Dr. Fesco said. "Right now, Illinois is an insurance-driven market, and we've all seen the impact [that] insurance-driven management has on clinical care. With the PSO's help, we can establish a strong, physician-driven alternative."

Dr. Fesco noted that the committee that oversaw the development of the conceptual business plan for the PSO relied

(Continued on page 14)

Cook County judge rules cap on noneconomic damages unconstitutional

DECISION: Judge's ruling on \$500,000 limit not precedent-setting, since other courts could uphold cap. BY KATHLEEN FUREORE

[CHICAGO] On May 22, Cook County Judge Kenneth Gillis declared unconstitutional the 1995 tort reform provision capping noneconomic damage awards in civil liability lawsuits at \$500,000. "I do not believe that it can be said that [the provision] has a rational basis, either to distinguish between economic or noneconomic damages, or to limit noneconomic damages, or to limit them for persons (or estates) which suffer catastrophic amounts on noneconomic damages," Gillis wrote.

He also called the provision "special legislation" and said the cap "presents a more invidious, and secret, way of

TORT REFORM

undermining the right to a jury trial than any [law] heretofore designed." In addition, the law violates the separation of powers and the section of the 1970 Illinois Constitution that guarantees remedies "in the laws" for individuals who are injured or wronged, Gillis wrote.

Securing passage of tort reform legislation with a \$500,000 cap was ISMS' top priority during the 1995 spring legislative session. The legislation, prompted by the Illinois Civil Justice League as

well as ISMS, was signed into law by Gov. Jim Edgar on March 9, 1995.

"Illinois physicians are deeply disappointed in this trial court decision," said ISMS President Sandra Olson, MD. "Although only one stop on the long road to meaningful lawsuit reform, it will slow our efforts to limit the growth of health care costs and make it harder for people in underserved areas to get the health care they need. The people of Illinois said they needed the wastefulness of our predatory legal system curbed. The legislature acted responsibly to meet that need [by passing the

(Continued on page 11)

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Program focuses
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Deadline nears for code guidelines

REMINDER: As of July 1, claims submitted with truncated ICD-9-CM diagnosis codes will be denied and will need to be resubmitted. BY KATHLEEN FUREORE

[WASHINGTON] New guidelines from the U.S. Health Care Financing Administration require Medicare carriers to deny as unprocessable, with no right to appeal, claims for physician services submitted with truncated ICD-9-CM codes beginning July 1, according to HCFA. Claims submitted with no diagnosis code or with unspecified codes using a series of 9s will also be denied, according to HCFA. The guidelines implement 1988 Omnibus Reconciliation Act requirements for diagnostic coding to be as specific as possible.

The Illinois Department of Public Aid has noted an increase in the number of Medicaid claims submitted with unspecified coding. As a result, IDPA is reviewing those claims and may consider making procedural changes, according to an ISMS analyst.

Truncated diagnosis codes are those submitted without the appropriate fourth or fifth digit. A three-digit diagnosis code, for example, is common on physicians' claims for diabetes mellitus. But under the new guide-

lines, the carrier will reject or delay claims for that disease that are not coded with five digits. Adding extra digits to codes that require only three digits will also result in delay or denial.

Nonassigned claims with truncated diagnosis codes will be suspended, and doctors will receive a letter from the carrier asking for more information, according to Kathy Shaheen, senior analyst in the Medicare Part B Provider Education Office. Assigned claims with truncated ICD-9-CM codes will be denied, and the carrier will require physicians to resubmit the claims using the most specific diagnosis code, according to a letter from the Medicare Part B Technical Services Department. Doctors should consult the 1996 edition of the International Classification of Diseases

9th Revision, Clinical Modification, 5th Edition for appropriate codes, Shaheen said.

ICD-9 code books are published by a variety of sources — the Practice Management Information Corp., the AMA, Medicode Publications, St. Anthony's Hospital and McGraw Hill. Most carriers use the PMIC version, but the information in each publication comes from the same source. Physicians should use the most current version of the manual, since the publication is updated annually, according to an ISMS analyst. Members who have questions may call ISMS' health care finance division at (312) 782-1654 or (800) 782-1654.

AMA members may order any of the 1996 coding manuals at reduced rates by phoning (800) 621-8335.

Ron Ackerman



REP. ROSEMARY MULLIGAN (R-Des Plaines) voices her concerns about managed care during a May 13 ISMS-sponsored dinner for physicians and legislators in Springfield. See story, page 3.

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BET



Illinois AIDS cases drop

[SPRINGFIELD] The number of reported Illinois AIDS cases dropped 28 percent last year, according to the Illinois Department of Public Health. The decrease from 3,040 reported cases in 1994 to 2,186 reported cases in 1995 was the first annual reduction since the first case was recorded in 1981, said IDPH Director John Lumpkin, MD.

"It is too early to tell if this signals that AIDS cases have peaked in our state, but hopefully this is the start of a downward trend," Dr. Lumpkin said. "What the statistics do provide is evidence that national, state and local education and prevention efforts initiated over the past decade are having an impact." Clinical advancements in treat-

ing HIV-infected patients have also helped delay disease progression.

HIV infection was the leading cause of death in 1994 (the most recent year for which complete death statistics are available) for Illinois' black males between the ages of 25 and 44, and the second-leading killer of all young adults in that age group. Although men still account for 82 percent of reported AIDS cases, the disease continues to climb among women. Females accounted for 18 percent of the cases reported in 1995, compared with 15 percent in 1994 and 10 percent in 1991. African-Americans and Latinos accounted for 65 percent of all new cases reported last year, IDPH said.

"Among the changing facets and

aspects of this epidemic, the one trend that has remained disturbingly constant is that African-American men and women are over-represented in every AIDS behavioral risk category," Dr. Lumpkin said.

AIDS cases decreased by 30 percent in Chicago and by 31 percent in the Chicago metropolitan area. Downstate saw a 7 percent decline in cases, yet an increase in its proportion of the state's total reported cases, from 11 percent in 1994 to 14 percent in 1995.

Although the decrease in AIDS cases is encouraging, Dr. Lumpkin cautioned against complacency. "The human toll in lives and suffering is staggering. We must continue to remind people that sexual and drug using behaviors can place them at risk of HIV infection and to encourage them to use that information in making informed choices." ■



ILLINOIS SECRETARY OF STATE

George Ryan joins transplant recipient Amber Blaisdell during the National Transplant Society's "Celebration of Life" recognition dinner April 25 in Chicago. Ryan delivered the keynote address.

Campaign promotes stroke education

[PARK RIDGE] The American Association of Neurological Surgeons has launched a campaign aimed at health care providers to promote improved response to and management of stroke patients. The project - "Brain Attack: A Body of Knowledge, A Coalition of Support" - portrays a stroke as a medical emergency that should be treated with the same urgency as a heart attack. Joining AANS in the effort are the American Academy of Neurology, the American College of Emergency Physicians, the American Society of

Neuroradiology, the National Institute of Neurological Disorder and Stroke, the National Stroke Association and the American Association of Neuroscience Nurses, according to an AANS spokesperson.

The campaign targets health care professionals such as neurosurgeons, neurologists, family physicians, internists and emergency physicians who typically have early contact with stroke victims. The coalition of organizations has recruited more than 900 physicians throughout

the country to present classes that cover clinical management and acute intervention for stroke. Each volunteer will make at least three presentations in clinics, teaching hospitals and elsewhere.

The impetus for the campaign was the "benign neglect" approach in caring for acute stroke victims, even though studies have shown improved outcomes for stroke patients who receive early intervention, according to AANS information. Emergency departments, for example, frequently consider stroke patients to be a moderate to low priority, the AANS said.

"Brain Attack" hopes to promote "ultra-rapid triage, transport, evaluation

and treatment of suspected stroke patients," the syllabus said.

Stroke is the third leading cause of death in this country, with some 500,000 new cases diagnosed each year, according to AANS. ■

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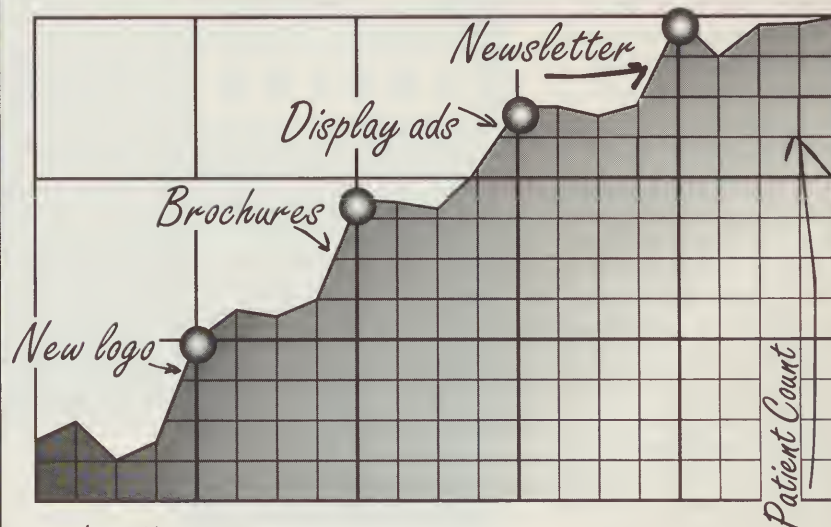
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Program focuses on managed care

DISCUSSION: Doctors, legislators describe patient woes.

BY JANICE ROSENBERG

[SPRINGFIELD] Physicians and legislators discussed problems and legislative solutions related to managed care at an ISMS-sponsored dinner May 13 in Springfield. "We're here because we want to work with you to solve problems so that our patients will get the kind of quality medical care they deserve," said ISMS President Sandra Olson, MD.

Physicians described managed care problems their patients have experienced.

ISMS President-elect Jane Jackman, MD, a family physician in Springfield, cited the example of a teen-age patient who confided that she had suffered from bulimia for 10 years. Although Dr. Jackman wanted to counsel her patient, the teen's managed care plan administrator said Dr. Jackman was not paid to provide such care. Instead, the plan advised the patient to call an 800 number for a referral to a psychiatrist or psychologist.

The patient then had the option of seeking treatment if she was emotionally able to request it, Dr. Jackman said. "She finally plucked up the courage to tell [me] about her problem. But I couldn't treat her, and that left me feeling concerned about all managed care patients getting appropriate treatment."

Linda Brubaker, MD, a urogynecologist at Chicago's Rush-Presbyterian-St. Luke's Medical Center, said one of her patients was for a time flatly denied coverage for a hysterectomy. The managed care plan instead suggested a less expensive procedure that Dr. Brubaker considered experimental.

Legislators also shared frustrations. Rep. Rosemary Mulligan (R-Des Plaines) expressed anger about a constituent with an ovarian tumor that went undiagnosed for some time, despite her symptoms, because her plan's primary care physician didn't order appropriate tests. "She had to pay for a second opinion [that detected the tumor] herself."

Sometimes services that physicians and patients consider essential are not covered by managed care, according to Mary Dobbins, MD, a pediatrician in Springfield. "People sign up for a plan that offers pediatric services, then find that well-child checkups aren't covered."

The ISMS-developed Managed Care Patients Rights Act would require plans to state up front what they cover, Dr. Jackman said. MCPRA was introduced in the Illinois House and Senate in early February to help protect the physician-patient relationship from intrusion that could compromise the quality of care. The bill did not emerge from committee,

but it has strong bipartisan support. Aspects of the bill may be reshaped before its reintroduction in early 1997.

A managed care-related bill that passed both the House and the Senate this session was sponsored by Rep. Kay Wojcik (R-Schaumburg) and Sen. Robert Madigan (R-Lincoln). The measure requires minimum insurance coverage of

48 hours of inpatient care following a vaginal delivery and 96 hours of inpatient care following a birth by cesarean section. The bill is on Gov. Jim Edgar's desk.

More bills are needed to support the physician-patient relationship, said Janis Orłowski, MD, associate dean of medical sciences and services at Rush and ISMS Third District trustee. "When you interfere with patient-physician relationships, you mess up something that's been going well for 2,000 years."

Legislators also voiced hope that future bills can help. Mulligan sponsored H.B. 2574, which mandates that insurers allow women to designate Ob/Gyns as

primary care physicians. The measure passed the House and was under consideration by the Senate as Illinois Medicine went to press.

Legislators were grateful for the chance to hear about managed care issues from physicians: "The best way to learn the problems doctors are having is by hearing the stories they have to tell," said Rep. Patricia Reid Lindner (R-Sugar Grove).

Rep. Judy Erwin (D-Chicago) agreed and suggested that employers be included in future health care dialogue. "They need to be reassured that the high quality health care their employees are receiving is worth the money they spend." ■



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REPORT for Illinois Physicians

MEDICARE

MEDICARE COVERAGE OF DIAGNOSTIC PAP SMEARS

A diagnostic pap smear is a laboratory study involving the collection and microscopic analysis of cells from the cervix and vagina for the early detection of cancer. A diagnostic pap smear and related medically necessary services are covered under Medicare Part B when ordered by a physician under one of the following conditions:

1. Previous cancer of the cervix, uterus, vagina that has been or is presently being treated;
2. Previous abnormal pap smear.

The specific conditions for which a diagnostic pap smear are covered include: any abnormal findings of the vagina, cervix, uterus, ovaries, or adnexa; any significant complaint by the patient referable to the female reproductive system; or any signs or symptoms that might in the physician's judgment reasonably be related to a gynecological disorder.

Documentation is required only when submitting a claim with a diagnosis not listed in the covered ICD-9-CM codes. Suggested documentation would include physician progress notes with pertinent medical history, physical examination findings and laboratory results.

Beginning with dates of service on and after July 15, 1996, submission of a claim to Medicare for diagnostic pap smear with other than a covered ICD-9-CM code will be denied without supporting documentation.

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EDITORIAL

Civility and mental illness

For people living in a civilized country, we Americans have been downright primitive about mental illness. Its victims have been made the butt of jokes, considered a source of embarrassment, characterized as flawed or just ignored. We may have abandoned physical abuse as a so-called treatment, but the stigma has lingered too long.

Fortunately, some celebrities have gone public about their personal experiences. Writer William Styron described the depression for which he was institutionalized in his book "Darkness Visible"; newsmen Mike Wallace discussed his depression and treatment with Zoloft on "60 Minutes" and on Capitol Hill; and Katharine Hepburn wrote about her brother's childhood depression and suicide in her recent memoirs. Perhaps such candor is helping to reveal these disorders for what they really are – illnesses that can afflict anyone, including intelligent, functional people. In Newsweek, Styron said that mental illness seems to be losing its stigma in the way that cancer finally did.

The Illinois Psychiatric Society says mental disorders are as definable and treatable as any other disorders. Most chronic diseases, including mental disorders, have physical, environmental, genetic and psychological components and are treatable, according to information from IPS. In fact, the society reports a treatment success rate of 80 percent for panic disorder and bipolar disorder. So, if mental illness can be diagnosed and treated,

why exclude it from coverage?

Some say the cost is excessive. But consider the cost of nontreatment. Mental health problems can masquerade as other illnesses, generating expensive, unnecessary testing. The feature story in this issue explores Munchausen by proxy syndrome, whereby a parent fabricates or induces health problems in a child. In a suspected Munchausen case in Florida, a child accumulated medical bills of \$3 million, according to USA Today. Failure to diagnose mental illnesses like panic disorder can be expensive. The IPS estimates that proper diagnosis could save \$33 million a year – the cost of unnecessary angiograms for sufferers who appear to be having heart attacks.

This spring, bills were introduced in the Illinois House and the U.S. Senate to establish more parity between mental health insurance coverage and other medical coverage. ISMS supported both H.B. 3630, which failed to emerge from the Illinois House, and the Kassebaum-Kennedy Senate bill, which will be reworked by a conference committee.

The Society's House of Delegates policy states that governmental coverage and private health insurance policies should not discriminate in providing benefits for the medical care of psychiatric illness.

Failure to cover and treat mental illness costs us all in misspent health care dollars, unnecessary patient suffering and workplace problems. Those are expenses we can't afford. ■

PRESIDENT'S LETTER

Death wish

Sandra F. Olson, MD



What about writing death prescriptions, e.g., for a gun? Do we ask, What kind or size would you like?

Publicity surrounding the recent court decisions in Washington and New York and the recent acquittal of Dr. Jack Kevorkian in three cases of assisted suicide have escalated our nation's awareness of this issue. It's impossible to read a newspaper or a magazine, or listen to a TV interviewer or talk show host and not confront this topic. The court decisions that I alluded to do not specifically permit this act; what they do is prohibit a ban on it. A fine point, perhaps, but one that may prove to be important legally in the future.

Courts have now said that patients have a right to commit suicide with a physician's skill and expertise if they so choose. But is it ethical for physicians to intentionally administer a lethal substance for the sole purpose of causing death? Ethicists have debated and determined that prolonging dying by feeding terminal patients or keeping the brain-dead patient on a respirator against his or her wishes is not in anyone's best interest, especially the patient's. Some proponents of physician-assisted suicide say the passive and ethically sanctioned act of withdrawing life-support measures is exactly the same as the active process they recommend and is even more cruel.

The passive act of permitting death or relieving pain with medication even though it may hasten the inevitable outcome, has been clearly accepted by the medical, religious and lay communities. This has been the policy of ISMS and that of organized medicine at many levels. We also have a policy against physicians participating in executions and suicides. The Hippocratic Oath, hallowed for years, prohibits the practice of intentionally giving the patient a means to die.

Pope John Paul II warned about a "culture of death" we're developing as a society. A recent poll by USA Today, CNN and Gallup showed 75 percent of Americans support physician-assisted suicide. In the Netherlands, a country of 15 million, this concept is support-

ed, and recent data provides a chilling fact. A commission showed almost 12,000 patients were euthanized with active measures in 1990. But half had not given consent.

As society continues to examine this issue, a new language is evolving – we now have a word for committing a physician-assisted suicide – Kevorkianize. Dr. Kevorkian was acquitted in his last trial because he said his primary purpose was to relieve suffering in people who were in great pain, but who were not terminally ill. Dr. Kevorkian recommends developing a group of salaried physicians who are certified by the medical profession to carry out this practice.

And to show how we are progressing administratively, the New York commissioner of health, Barbara DeBuono, is being proactive in exploring "suicide options" and drafting guidelines for this practice! Really!

The next step will be to assign a DRG code. What about writing death prescriptions, e.g., for a gun? Do we ask, What kind or size would you like? OK, we will write one for a .357 Magnum – will that be one bullet or two?

Two recent articles in the New England Journal of Medicine report on questionnaires mailed to physicians and intensive care nurses about requests for the means to commit suicide or euthanasia. Sixteen percent of the physicians and 17 percent of the nurses had received requests for help with one of these practices.

The public debate on this issue is clearly escalating and appropriately so. As noted above, polls are reporting public opinion to be favorable to these practices. However, we must not just focus on the legalities. Ethics for the medical profession must not be pre-empted or set aside. Are we already on a slippery slope? If so, where are we going, and what will be our ultimate outcome? What is our role as a physician? As a profession? Who decides? ■

GUEST EDITORIAL

A \$2,000 health care trick

By James K. Glassman

Copyright 1996, James K. Glassman.

Between 1974 and 1982, the Rand Corp. conducted a giant experiment for the U.S. Office of Economic Opportunity to find out how the country would respond to different kinds of health insurance.

The results were startling and, until now, largely ignored. But they could have a major bearing on today's most important health care debate: the fight over medical savings accounts.

While the issue sounds arcane, it's vital to the country's economic future. MSAs may be the answer to stopping runaway health costs by freeing people to make their own decisions.

A total of 3,958 Americans in 2,005 families took part in the Rand study. Each family was randomly assigned to an insurance plan for three to five years. One plan provided completely free care. Others required families to pay a share (25 percent, 50 percent or 95 percent) of the bills up to a point where a catastrophic policy kicked in. Here's what Rand found:

First, families that received free care used far more medical services than families that paid for part of their care.

For example, families with free care had one-third more hospital admissions than families that paid 95 percent of their own health bills. The free-care families incurred medical expenses of \$777 per person (in 1984 dollars) whereas families that paid 50 percent of their own bills spent \$583 per person.

These findings are common sense. When you spend your own money for something, you're more apt to spend it wisely than if the government, your employer or an insurance company is footing the bill.

But, with your own dollars at stake, will you stint on care you really need and thus damage your health? Rand, in its second key discovery, says no.

"Free care," the study concluded, "had at most a small effect on any of

five general health measures for the average enrollee." Thus, Rand said, free care "is not justified by the health benefits realized."

Which brings us to the hot health care issue of the moment: MSAs. The House and Senate will decide soon whether to include MSAs in the final version of the Kassebaum-Kennedy bill, which tries to make health insurance more accessible and portable.

I'm no fan of Kassebaum-Kennedy, since it will lead, inevitably, to an expensive Washington-controlled national health system that will restrict personal choices. MSAs, on the other hand, could be our passage out of the horrendous swamp of our current system.

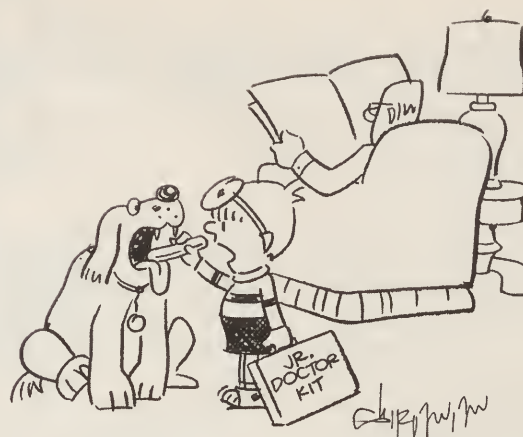
An MSA is a health insurance policy that's divided into two parts: For the first part, a family pays its own health costs up to, say, \$2,000 a year. For the second, the family's expenses beyond \$2,000 are covered by a catastrophic policy.

Based on what Rand discovered, we can expect families to shop wisely for health care when their own dollars are at stake. That wise shopping – and judicious use – should have the effect of limiting increases in health care costs overall.

In other words, by bringing the consumer directly into the health care market, supply and demand pressures take hold – just as they do with any other market. Health care providers will respond to price-sensitive consumers, as dry-cleaning providers or fast-food providers do now. The current system of government constraints and managed care has proved that it cannot hold down costs – though it can generate tons of paperwork and infuriate lots of people.

But where will a family get the \$2,000 to pay its initial medical bills?

Enter MSAs. If you have an MSA at



"Don't bite it. I have to check Daddy next."

work, your employer puts \$2,000 into an account in your name. You then use that account to pay your bills for the year. It becomes, in effect, first-dollar insurance – a boon to the poorest working Americans, who, under policies today, have large deductibles or copayments.

When an MSA's initial \$2,000 is used up, the catastrophic policy kicks in. At the end of the year, you keep any of the \$2,000 you haven't used. (Under the proposed law, the money goes into a tax-free savings account, like an IRA. So pay attention, Citicorp and Fidelity.)

In effect, you're spending your own money on health care – with the kinds of beneficial results that the Rand study predicts.

MSAs already exist. Pat Rooney, chairman of Golden Rule Insurance Co., which writes MSA policies, says that more than 1,000 companies (including his own) are using them now, to the general pleasure of their employees. Among the participants in MSAs: the United Mine Workers union.

A typically enthusiastic user of MSAs is Penny Blubaugh, who makes \$16,000 a year as a secretary in the Danville, Ohio, school system. She recently testified before the Senate Finance Committee and later wrote to President Clinton about how "my daughter stepped on a nail in our garage, and I was advised to take her to the emergency room. This trip cost \$375 for the emergency room

and \$70 for reading X-rays."

She didn't have \$445, but her MSA did. It gave her first-dollar coverage. "As for the things I heard last week in Washington about the medical savings [accounts] being only for healthy and wealthy people, that is 'bunk,'" Blubaugh wrote.

The average employer's premium on an MSA policy (with a \$2,000 deductible) is \$2,300 per family, compared with \$5,000 for a conventional health insurance policy, according to Golden Rule. So, an employer that provides the \$2,000 for out-of-pocket expenses comes out ahead. (Meanwhile, workers under some MSA plans get to keep an average of \$1,000 a year for their own use.)

If my wife and I were still running a business, we'd sign our company up for an MSA tomorrow – even though the tax consequences are utterly unfair.

Taxes are what the new MSA bill addresses. Under current law, premiums on employer-paid health insurance are not taxable to employees who benefit from them – but deposits by employers into employee MSAs are. Under the new bill, MSA accounts wouldn't be taxed.

The loss to the Treasury would be tiny, but the benefits could be huge. MSAs would put Americans themselves in charge of spending their medical dollars, increasing choice and personal responsibility – and lowering costs. Now, that's a good deal. ■

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Opposition to gag rules builds nationwide

ADVOCACY: State and federal legislatures consider banning gag clauses as some managed care plans drop them voluntarily. BY JULIE A. JACOB

[CHICAGO] Legislative efforts are under way at the state and federal levels to prohibit or nullify gag clauses in managed care contracts. Massachusetts and Colorado have already passed laws banning them, and seven other states – Illinois, California, Indiana, New Jersey, New York, Ohio and Tennessee – are considering similar legislation, according to Jack Segal, AMA senior public information officer.

In addition, Arizona and Wyoming have adopted disclosure requirements forcing HMOs to tell consumers if physicians receive financial incentives for reducing hospital stays or minimizing specialist referrals, according to the Chicago Tribune.

At the federal level H.R. 2976 – sponsored by House Commerce Committee members Greg Ganske, MD (R-Iowa) and Ed Market (D-Mass.) and developed with help from the AMA – would ban the use of gag clauses. The bill has 45 sponsors, and hearings were expected to be held around Memorial Day, according to the AMA.

Some insurers say gag clauses are not an issue. “None of our managed care contracts have any language in them that prevents physicians from discussing treatment options with their patients,

even if they aren’t covered by the insurance plan,” said Walt Cherniak, a spokesperson for Aetna Life & Casualty Co. “In fact, we encourage physicians to talk with their patients about treatment options.”

Aetna contracts do, however, state: “Consulting physician shall address any disagreements, disputes or other grievances concerning Aetna payors or sponsors and their respective policies and procedures to Aetna, and the parties shall endeavor in good faith to resolve same. In no event shall consulting physician disclose to or discuss, directly or indirectly, such disagreements, disputes or grievances with members, payors, sponsors, representatives of the broadcast or print media or any other person or entity.”

EVEN IF CONTRACTS do not explicitly forbid physicians from discussing noncovered treatment options with patients, clauses prohibiting doctors from disagreeing with the plan when communicating with patients or making statements that encourage patients to switch health plans can potentially be used to gag physicians, Segal said. That’s why the AMA is encouraging physicians and insurers to submit their contracts to the AMA for a

free legal analysis, he noted. So far the AMA has reviewed about 100 contracts, Segal added.

Last month Aetna announced its purchase of U.S. Healthcare Inc., which stated in early February that it was replacing a clause that restricted what physicians could say with a provision protecting their freedom of speech, according to the Associated Press.

In late March, two other insurers – HealthNet Inc., which is operated by eight Kansas City-area hospitals, and Blue Cross and Blue Shield of Kansas City – said they were removing gag rules regarding treatment options or disparagement provisions, according to AP.

Kaiser Permanente of Ohio announced in April that based on its consultation with the Ohio State Medical Association, it would clarify contract language that could be interpreted as gag clauses, according to Melvin Mulder, MD, medical director at Kaiser Permanente. “These clauses conflict directly with our mission of delivering quality health care and focusing on patient needs. Further, gag clauses conflict with the physician’s Hippocratic Oath to put patient needs above all else. We encourage all health plans to take a close look at their contracts with physicians and

clarify all confusing language.”

“The physicians of Ohio applaud Kaiser,” said Jack Summers, MD, president of the Ohio State Medical Association. “This cooperative effort illustrates what physicians and managed care organizations can accomplish when they work together.”

IN ILLINOIS, the Managed Care Patient Rights Act, developed by ISMS, would prohibit insurers from including gag language in their physician contracts. “We developed the bill because of the whole health care environment right now,” said ISMS Past President Raymond Hoffmann, MD, citing such problems as gag rules and preauthorization for emergency care. “We had been hearing questions and complaints from our members about these issues, and we felt it was time to stand up for patients and see that [their] rights are addressed.”

As Illinois Medicine went to press, the bill was still in the House Rules Committee. However, it will be considered again when the state legislature reconvenes in the fall, said Rep. Tom Cross (R-Yorkville), the bill’s lead House sponsor. “If we can get it out of committee and called, there’s a very good chance that it can pass,” he said. “There are about 30 sponsors and a lot of support for it.”

Dr. Hoffmann expressed confidence in dealing with gag rules through the legislative process: “Legislators are listening. If legislators think gag rules are restricting the quality of care for patients, they will act on it.” ■



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ISMIE Update

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Problem lists, medication flow sheets can help reduce risk

Forms put important patient information at physicians' fingertips.

BY KATHLEEN FUIRORE

Physicians can improve patient care and reduce liability risks by routinely using problem lists and medication flow sheets, according to some medical malpractice defense attorneys. Doctors and their office staff can develop both types of forms, customizing them to meet their needs. The medication flow sheets might include such information as dosage, refill status, special instructions, the date and reason for discontinuation and reactions. Problem lists can address patients' acute and chronic health problems, incorporating the dates of occurrences, a summary of the problems and the dates they became inactive or were resolved.

"[The forms] let a doctor be brought up to speed in a much more expedient way than flipping through a patient's chart," said David Burtker, an attorney with French, Kezelis & Kominiarek in Chicago. "They give physicians the ability to look at something and follow the time line, the problem line, the medication line all the way through."

Medication flow sheets let physicians immediately see how a patient responded to a particular medication or family of medications, said attorney Bill Rogers of Chicago's Bollinger, Ruberry & Garvey. "It's a quick reference point — did we use that [medication] two years ago?"

Henry Martin-del-Campo, MD, a family physician in Peoria and a medical director at Peoria's Methodist Medical Center, uses problem lists and medication flow sheets. "In any group practice, when one of your colleagues is called upon to treat one of your patients, [using the documents] is the most efficient and safest way to practice. They remind you immediately about treatment plans and medication options you can use." Solo practitioners can use the forms to better document and coordinate medications prescribed by other

doctors, he added.

Solo practitioner Martin Goldstone, MD, a River Grove internist, has used problem lists and medication flow sheets for the past few years. "A lot of patients might forget [what they are taking or have taken]. And I find it easier if I write the medications on one sheet instead of having to go through all the progress sheets. Also, if I change something, I can note it on the medication list. Two or three years later I might want to use a medication that [the list would show] hadn't worked."

Dr. Goldstone added that the lists also save time. "I can say 'see medication list' or 'see problem list.' I don't have to rewrite everything." He added that the lists facilitate office evaluations by managed care entities.

The Joint Commission on Accreditation of Health Care Organizations and the National Committee for Quality Assurance also require the forms, Dr. Martin-del-Campo said.

Burtker said he doesn't usually see the forms in his clients' charts and cited a recently settled case to illustrate their importance. A 2-day-old infant with abdominal distention was transferred to the neonatal intensive care unit with a possible diagnosis of Hirschsprung's disease. But when the child passed meconium, physicians suspected meconium plug syndrome. The child was transferred back to the nursery after the distention disappeared. After three days, a pediatrician in the nursery discharged the baby with a diagnosis of meconium plug syndrome. Three weeks later the child died of a ruptured colon.

"The pediatrician who discharged the baby and dictated the summary was not in the neonatal ICU," Burtker said. "She believed the baby had meconium plug syndrome because that was what was on the chart. But if there had been a

problem list, Hirschsprung's disease would have been on it. And the pediatrician could have caught it because there would have been no resolution — it would have been hanging there."

Burtker said plaintiffs' attorneys typically consider the discharging physician to be the gatekeeper in hospital settings.

"The physician dictating the discharge summary may not be the attending physician. It may be a resident. And I've seen problems that have arisen during the course of admission go by the wayside. A problem list hopefully [keeps] someone who is not familiar with a patient and who is doing the discharge summary from overlooking anything. It allows everyone a second, third or fourth chance to review problems."

Although their benefits are many, the documents could cause problems if not used effectively, Burtker said. "What you don't put on the problem list will be viewed [by plaintiffs' attorneys] as not being signifi-

cant in your mind. I suspect it can give rise to a question of fact in a lawsuit: Did you see a lab result? And if it was of concern to you, why is it not on the problem list?"

Lists that aren't current could also raise red flags, Burtker said. "Say you're trying to control a patient's diabetes. If there is any indication of a problem and no definitive statement as to the resolution, and that problem becomes an issue [in future litigation], you're going to have to explain it."

For sample lists and flow sheets, call ISMIE's risk management division, (312) 782-2749 or (800) 782-4767, ext. 1327. ■

ISMIE contracts with four more brokers

Geographic representation becomes broader.

BY KATHLEEN FUIRORE

The roster of brokerages authorized to represent ISMIE and sell ISMIE products is now five companies strong with the addition of Classic Insurance Services Ltd., Diederich Insurance, Medical Arts Insurance Affiliates Ltd. and Medical Group Insurance Services. The companies recently signed contracts with ISMIE, joining Aon, the first brokerage with which ISMIE contracted. This approach is to expand the range of products and services offered policyholders, said Harold Jensen, MD, chairman of the ISMIE Board of Governors.

ISMIE decided to work with brokers because of the escalation of managed care, which is casting nonphysicians (like group practice administrators) in insurance-buying roles. Dr. Jensen remarked, "Working with these companies and with Aon will give ISMIE even broader geographic representation and better access to a variety of market segments." He added, though, that physicians, groups or clinics can continue to buy directly from and maintain contact with ISMIE.

Working with brokers won't affect the cost of ISMIE coverage.

Classic Insurance Services,

based in Oak Brook, offers a full range of products and services. Owner Vince Lovelle, a general insurance broker for the past 22 years, subspecializes in and currently writes some \$5 million in medical professional liability insurance. "We represent all major carriers for medical malpractice in Illinois, so we can offer your members a breadth of market," Lovelle said. "One of our big strengths is the group business."

Carbondale-based Diederich Insurance writes all lines of coverage but specializes in medical professional liability. The company is headed by Richard Diederich, who has been a licensed broker in Illinois for some 25 years. He says the company writes some \$18 million in total premiums annually. "We are very dedicated to medical professional liability insurance and have a separate division devoted to it," Diederich said. "In fact, we've had a dedicated staff working with physicians for the past 20 years, so we bring a high level of expertise to the table that your physicians can benefit from." Diederich said his company is prepared to work with physicians who have questions that need immediate answers or who have immediate needs for insurance services.

MAI Affiliates of Lisle specializes in insuring group clinic practices. Owner Tom Cox has written and serviced medical professional liability insurance for more than 20 years and now insures 23 medical clinics in Illinois representing about 650 physicians. The annual premium volume for that business is almost \$8 million. "We can help improve communication concerning insurance coverage and the options available to physicians," Cox said.

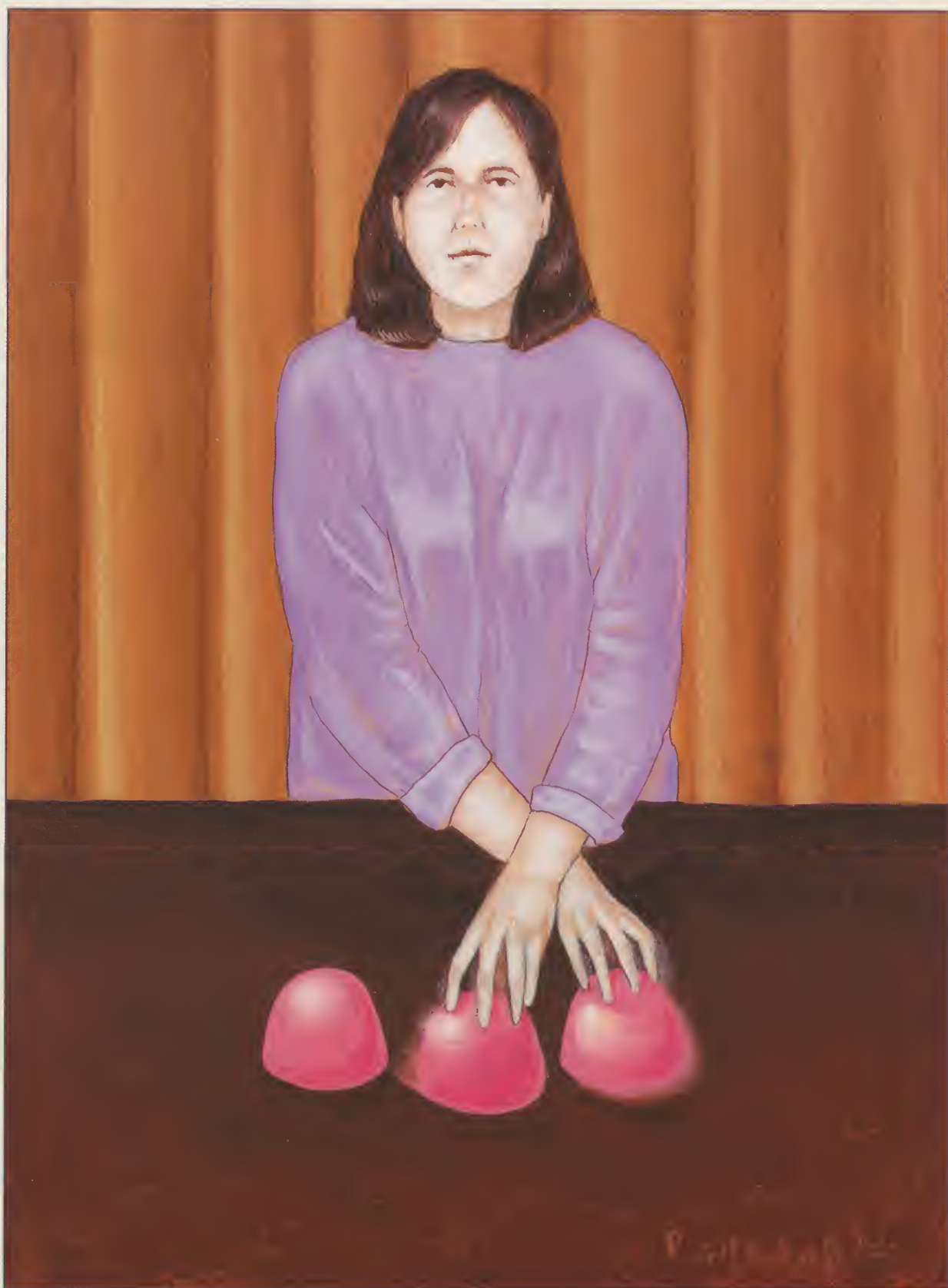
Headquartered in San Jose, Calif., Medical Group Insurance Services provides insurance products and services to medical groups through the Medical Group Managers Association. The company has specialized in "benefits work" for physicians since 1969 and has written professional liability policies since 1988. MGIS does between \$35 million and \$40 million in business for medical malpractice insurance alone, according to Bob Meyer, MGIS' director of marketing. "We are dedicated to physicians just the same way ISMIE is," Meyer said.

These four brokers are needed to help ISMIE retain its current business and help provide bids for new groups or opportunities they become aware of, Dr. Jensen said. They will also be able to help physicians with other insurance products such as the health and life policies needed in practice settings, he added. ■

Uncovering medical child abuse

A variation on Munchausen syndrome involves parental sleight of hand, posing a diagnostic challenge.

BY JANICE ROSENBERG



Bob Gherardi

A strange and deeply troubling syndrome that challenges physicians' beliefs about the parent-child relationship is receiving national attention. Parents who suffer from Munchausen by proxy syndrome systematically fabricate or induce health problems in their children as a perverse way of gaining the attention of a powerful authority figure – the treating physician. Children's puzzling symptoms and the difficult diagnosis confound physicians, especially pediatricians and psychiatrists who deal with it the most.

"One reason doctors may be slow in catching on to this disorder is our utter disbelief that children could be treated this way," said Philip Woollcott, MD, professor of psychiatry at the University of Illinois at Chicago College of Medicine. "It goes against the mother's strong protective biological instincts, and that's too dark a view of human nature for many people to accept."

Experts call the syndrome a form of child abuse. Although exact figures on its frequency are not available, a review of the literature and a survey of pediatric subspecialists suggest that it is not uncommon, according to Herbert A. Schreier, MD, and Judith A. Libow, PhD, in their book "Hurting for Love: Munchausen by Proxy Syndrome" (Guilford Press, 1993).

There are probably thousands of cases in the country, but many physicians say they "don't believe in MBPS," Dr. Libow said. Yet physicians owe it to their child-patients to consider it a possibility in cases that involve diagnostic puzzles.

"Parents do not need to administer drugs or induce illness to be classified as Munchausen by proxy syndrome cases," Dr. Schreier and Libow wrote. "They can manifest the syndrome less dramatically through all manner of clever misrepresentation of a child's medical history, his or her symptoms, or of lab specimens."

PHYSICIANS WHO BECOME familiar with the signs of the syndrome sometimes look back with new insight into cases that they once found difficult to diagnose.

"Most things we see, we solve, and that rules out Munchausen," said Emalee Flaherty, MD, a pediatrician at Columbus Hospital in Chicago. Dr. Flaherty said she remembers a case that, in hindsight, might have been related to the syndrome. "When I was a resident, there was a child who'd had multiple abdominal surgeries and died after one of them. It seemed bizarre then that there were no obvious reasons for the child's problems." Symptoms that do not respond to usual treatments, do not fit a particular disease or occur only with a particular caregiver are clues to MBPS, Dr. Flaherty said.

Yet even with the lack of a cause for severe problems and even with the knowledge of the possibility of MBPS, diagnosing it is far from easy, experts agreed. This is due in part to the personality of the parent, usually the mother, according to Steven Krug, MD, head of the division of pediatric emergency medicine at Children's Memorial Hospital in Chicago.

"In MBPS, the parents are usually very convincing and seem quite concerned, involved and caring," Dr. Krug said. "They're not people whom, when you've never met them before, would immediately make you suspect that something strange was going on."

An MBPS mother may appear devoted to her child and to seeking the very best care, but her complaints or reports about the child "are out of proportion to the lab findings," Dr. Woollcott said. He explained that indicators like the child's height and weight might be normal, "but the mother is describing big-time problems" that are inconsistent with the normal indicators.

When a physician thinks physical findings in a case are inconsistent with a serious or significant medical disorder as described by the parent or if a doctor is

pressed by the parent to perform invasive diagnostic procedures, he or she should consider the MBPS diagnosis, said D. Richard Martini, MD, a child psychiatrist and clinical director of intake and mobile services at Children's Memorial. MBPS parents give inconsistent histories, often do not appear to be upset about their child's illness and usually have considerable knowledge about it, he said. "But this is also true about a lot of parents, so you can't take these relatively subjective findings and call the case Munchausen."

Instead, Dr. Martini advised, a physician should obtain a very good medical history of the child. Physicians should gather data, request records from all consultants and fit that information into what they already know. Look for a history of the parent's having deliberately ignored documented recommendations or having done the exact opposite of those recommendations. Check for numerous hospital admissions, invasive tests or procedures and frequent visits to emergency departments. Be suspicious of a mother who is dissatisfied with suggestions for procedures that limit invasiveness.

"If when you ask the parent for permission to contact past consultants, she becomes anxious or leaves your office, that's a real warning sign that your suspi-

(Continued on page 10)

It's all in the lies

Munchausen by proxy syndrome is a variation of Munchausen syndrome, or factitious disorder with physical symptoms. Patients experiencing Munchausen syndrome habitually present at the hospital and give a plausible and dramatic – but false – history in conjunction with what appears to be an acute illness, according to Dorland's Illustrated Medical Dictionary. Some patients lie about their symptoms; others manipulate test results or self-induce symptoms.

The syndrome is named for Baron Karl Friedrich Hieronymus Freiherr von Munchausen, an 18th century German cavalry officer known for inventing colorful stories about his adventures.

The baron has a contemporary counterpart called the "Red Baron," according to a story reported in the April 22 edition of the Wall Street Journal. The Red Baron is a man in his early 30s who during the 1990s visited at least 14 hospitals from New Orleans to New Haven, Conn., seeking treatment for Goodpasture's syndrome, a rare disorder of the lungs and kidneys. His cover was blown by a Yale University hematologist who observed that the patient was able to converse glibly during an alleged episode of severe kidney pain. When the hematologist became suspicious that it was a Munchausen case and confronted him, the patient left the hospital. Since then, the Red Baron is believed to have sought treatment in New York state and Princeton, N.J.

"The only limits to factitious disorders are those of human creativity," said Stuart Eisendrath, MD, as reported by the Journal. A professor of psychiatry at the University of California at San Francisco, Dr. Eisendrath described a case in which a patient with a blood-clotting disorder had had a filter placed in his inferior vena cava to prevent clots from reaching his lungs. It turned out that the patient had been injecting himself with sea kelp. ■

– Lynn Koslowsky

Uncovering

(Continued from page 9)

cions may be true," Dr. Martini said.

The hardest cases to diagnose are those in which the child does not have a primary care physician, and the mother has "doctor shopped" and obtained multiple opinions, he added.

The syndrome is also a tough call for emergency department physicians, since they don't have ready access to a patient's medical history, Dr. Krug said. MBPS doesn't necessarily manifest itself in the same way as other abuse or neglect; it's more indirect, and the complaints are not

as straightforward, he noted.

Some doctors believe the syndrome may be overdiagnosed – the answer when they're frustrated and unable to treat a particularly tricky illness, said Peter Whittington, MD, director of the section of pediatric gastroenterology at the University of Chicago Hospitals. "I believe in the general goodness of parents, and I try to look very deeply into problems that theoretically could be due to abuse or neglect."

Yet not all cases are what they seem. Dr. Whittington has testified for the defense in several legal cases involving families accused of MBPS. In each case,

the children were suffering from a rare condition called intestinal pseudo-obstruction syndrome, which produces recurrent episodes of bacterial sepsis.

"I've cared for a number of these cases," Dr. Whittington said. "All their parents were accused at one time or another of injecting bacteria into their child's bloodstream. The reasoning went, Why else would the child have sepsis so often? This is a devastating, chronic, downhill disease, and for parents to be accused of sabotaging their own children or creating an illness is very, very unfair."

At the same time, missing an MBPS diagnosis may result in continued pain

and suffering, or even death, for a child. Doctors who are not careful can become unwitting participants, according to Dr. Schreier. He pointed to a recent case in Florida in which a child was admitted to the hospital nearly 200 times and underwent more than 40 surgeries, including removal of her gall bladder, appendix and part of an intestine. According to news coverage of the case, state authorities, who had been watching the case for several years, recently received a tip that the mother was putting feces in the child's feeding tubes. The girl was placed in protective custody, and the mother has been charged with abuse and fraud in obtaining unnecessary medical services.

Doctors who suspect MBPS should not attempt to make the diagnosis on their own, Dr. Schreier said. Instead they should consult with their peers or with a known MBPS expert.

TEAMWORK IS VITAL to establish evidence in MBPS abuse cases, said Carolyn J. Levitt, MD, a pediatrician and director of the Midwest Children's Resource Center at Children's Health Care in St. Paul, Minn. A year ago doctors at the center – in conjunction with a team of experts, including hospital ethicists and legal advisers, child protection authorities and local police – resolved an MBPS case involving a year-old child.

The child's mother contended that he had episodes when he stopped breathing. Videotape monitors eventually captured her smothering the hospitalized child with a pillow. She is on parole after she was arrested and charged with second-degree assault. The child's father is now his sole legal custodian.

"The only way we could protect this child long term was by proving his mother was involved," Dr. Levitt said. "The only way to do that was to see it on videotape."

Despite the videotape, the mother denies she did anything. "The question is, How can she get help for that?" asked Dr. Levitt. Therapy could address her personality disorder, she said, but might not be effective given her denial of it.

This mother's own history as an abused child fit a profile common to many MBPS mothers, as described by Dr. Martini. They often exhibit somatization or factitious disorder or are subject to malingering, he said.

MBPS involves the mother's need to maintain an intense, if perverse, relationship with the powerful authority figure that is her child's physician, according to Libow and Dr. Schreier. "The very act of seeking relationships with physicians by means of a pattern of behavior that endangers one's child suggests a desperate need for recognition and a problematic relationship to the act of caretaking," they wrote.

Psychotherapy is recommended for the parent and the child, but there is little information in the literature about treatment of actual cases.

Although there is no data on the long-term effect of MBPS on children, those who grow up under its influence are likely to be developmentally disturbed, according to Dr. Woolcott. Siblings in the home are also in danger.

"If the mother is taken out of the case with a younger child, the child improves," he said. "But some children who have spent their whole childhoods being told there is something wrong with them will assume it's the truth." ■

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(Continued from page 1)

cap]. ISMS remains confident that upon higher court review, the legislature's far-sighted and thoughtful action will ultimately be upheld."

Statistics, in fact, show tort reform was already curbing the "predatory legal system."

"Lawsuit reform, despite the obstacles, is working as it was intended," said Harold Jensen, MD, chairman of the ISMIE Board of Governors. "There were 758 lawsuits filed against ISMIE-insured doctors in the first two months of 1995, immediately before lawsuit reform was enacted. For the same period in 1996, the number of suits had dropped to 264 — a decrease of nearly two-thirds." As a result, ISMIE was able to reduce its premiums for new physicians by 16 percent. "New doctors entering practice after reform's enactment suffer a lessened malpractice insurance premium burden than they would without the law," he said.

"Tort reform ... resulted in a dramatic decrease in lawsuits," Rep. Tom Cross (R-Yorkville), a sponsor of the tort reform legislation, said.

And firms that once specialized in such lawsuits are finding they must now branch out into other areas of law, according to a recent article in the Chicago Daily Law Bulletin.

Gillis is the only judge in Illinois who has ruled on the cap, and his ruling is not precedent-setting, since other lower courts could uphold the \$500,000 limit.

The issue of the legislation's constitutionality is expected to be ultimately decided by the Illinois Supreme Court, according to ISMS General Counsel Saul Morse.

Because this decision is a procedural ruling, it is not clear whether there is a right to appeal it, Morse noted. "The judge would have to certify this decision in order to permit an appeal. That certification would have to come at the request of one of the losing parties." When a statute is held unconstitutional, the Supreme Court is required to take the appeal, but if a statute is upheld, appeal is at the court's discretion, Morse added.

In February, Gillis upheld as constitutional the tort reform provision that tightens the state's affidavit of merit requirement, which requires plaintiffs to provide the name and address of the physician or other health care professional who reviews a case and certifies its merit. But he also found two other provisions of the law unconstitutional at that time. One, which modifies the Petrillo doctrine, says patients who file medical malpractice suits must authorize the release of their medical records to the defendant within 28 days or the defendant can seek a court order to obtain the records or have the case dismissed. The other says hospitals are not vicariously liable for actions of doctors they do not employ. Gillis' rulings on these issues, like his decision on caps, are not precedent-setting and are expected to be appealed to the Supreme Court, Morse said.

The next issue of Illinois Medicine will continue coverage of the decision. ■

Rush North Shore Medical Center

Chairman Department of Medicine

Rush North Shore Medical Center seeks a senior physician executive to serve as Chairman, Department of Medicine.

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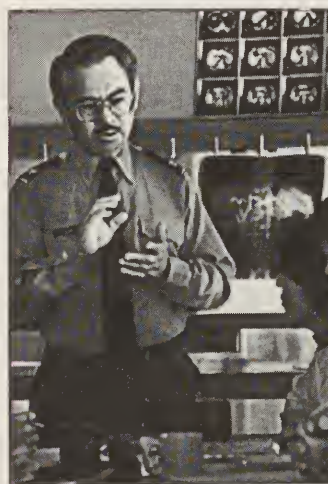
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1 insertion	\$ 7	\$17	\$25	\$ 42
3 insertions	13	32	46	78
6 insertions	18	44	64	108
12 insertions	22	53	79	132

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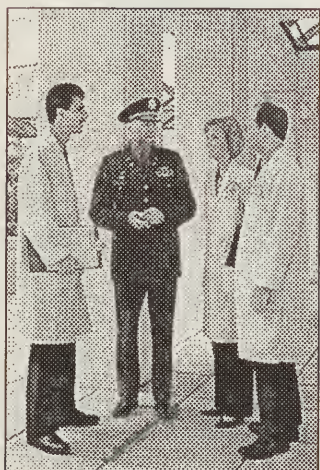
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For more information, please contact:

Dawn R. Hamman

OSF HealthCare System
Saint Francis, Inc.
4541 N. Prospect, Suite 400
Peoria, Illinois 61614
Phone 800-438-3740
Fax 309-685-2574

ISMS delegates

(Continued from page 1)

on member input, market research and their own experiences as practicing physicians. Based on all this information, the physician-owned and -operated Illinois Medical PSO will offer credentialing, contract management, utilization management, quality improvement, claims and capitation processing, financial management and reporting, and practice management services, Dr. Fesco said.

"The loudest message we heard in all our member research was that physicians want to maintain independence and clinical control over patient care," Dr. Fesco explained. "The PSO builds on the expectation that physicians – if given tools, expertise and administrative support – will collaborate to establish managed care and capitation-capable entities.

"The PSO will equip physician organizations to manage insurance risk and will create affordable access to information management systems that will improve our ability to manage financial risk and, more importantly, the process of caring for our patients," he continued. Although the organization will not contract directly with physicians for patient care services, it will enable physician organizations to do so more effectively, Dr. Fesco said.

To allow the PSO to offer the kind of specialized services members want and need, it was created as an entity separate

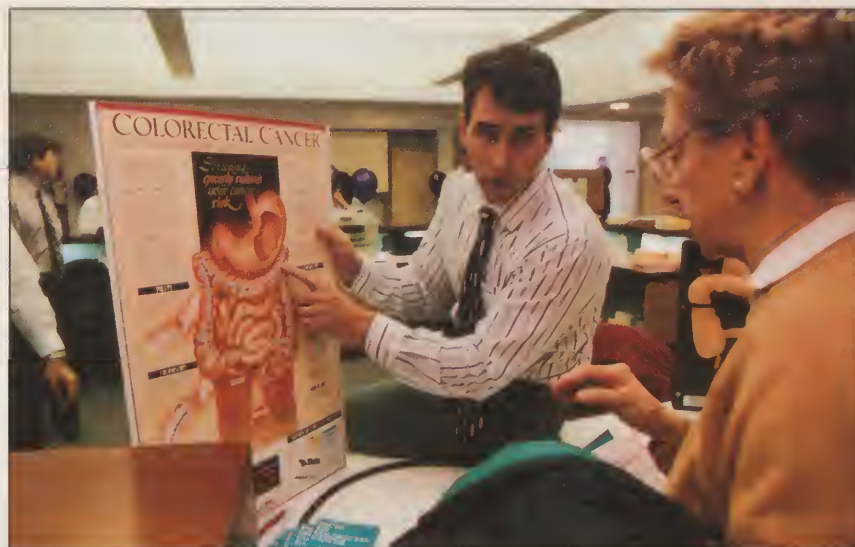
from ISMS, Dr. Fesco explained. "It creates a mechanism for financing services outside the dues structure," he said, noting that funds for the PSO have and will continue to come from a variety of sources.

"The PSO's start-up budget is bare-bones funding to provide for launching the entity and developing and releasing a capital offering to Illinois physicians," Dr. Fesco explained. "In fact, a major portion is devoted to legal, development and promotional expenses associated with the [capital] offering, which is a highly complex and heavily regulated endeavor." The stock offering must be registered with the secretary of state before information can be released, Dr. Fesco said.

The next step in the PSO implementation process is to select at least two beta sites in which proposed PSO services can be tested, Dr. Fesco noted. "The sites will be selected using guidelines approved by the PSO Board that were recently mailed to all members."

In closing, Dr. Fesco addressed the changing medical marketplace and physicians' role.

"The market will move, with or without us," he observed. "We must act with confidence to secure our leadership and maintain our promise of providing first-rate care to our patients. At all our leadership workshops and throughout the PSO planning process, we've used the slogan 'Seize the Reins of Change.' It is essential that we take control now, while we have the opportunity." ■



Vince Pierri

KENNETH SCHOENIG, MD, an ISMS member, participates in Cancer Awareness Day activities May 4 at Lutheran General Hospital's Cancer Care Center in Park Ridge. The center offered free cancer screenings.

Physician HELpline



ISMS' 24-hour Physician HELpline is available to link impaired physicians and their families with helpful resources.

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RERS APPEAL DENIAL OF RATE HIKES (PAGE 6)



*ISMS victories
highlight spring
legislative
session*

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JUNE 21 1996

**1996 ISMS
legislative
highlights**

PAGE 2

Legislative session ends May 25

State budget includes ISMS-backed Medicaid payment rate increase

BY KATHLEEN FURORE

[SPRINGFIELD] An ISMS-advocated 3 percent boost in the Medicaid payment rate for physician services, along with a decrease in the payment cycle, was part of the recently passed fiscal-year 1997 Illinois Department of Public Aid Medical Assistance Program budget. The General Assembly passed the state's budget at the end of session. The rate increase for doctors reflected in the budget's physician line appropriation is effective July 1, 1996.

The physician appropriation totals \$334 million, of which \$6.7 million is for the increase in payments. That increase could be targeted for specific services or procedures rather than apply across-the-board, said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee.

Although the new appropriation is less than the \$369.7 million appropriated for FY '96, the physician line is "in good shape, even with the decrease," said an ISMS analyst. That is

because the liability - or bills received - for FY '96 is projected to total \$322.2 million. That number subtracted from the \$369.7 million appropriation leaves an excess of roughly \$47.5 million in funds. IDPA was to transfer \$32.3 million of the excess to other lines while using the remaining \$15.2 million to pay off old bills. Consequently, bills on hand as of June 30, 1996, should be \$15.2 million less than bills on hand by the same date last year. That reduces the payment cycle from 25 days to about nine days as of June 30, the analyst said. The
(Continued on page 11)



Ron Ackerman

MCPRA to continue as work in progress for Society and supporters

BY KATHLEEN FURORE

[SPRINGFIELD] The Managed Care Patient Rights Act developed by ISMS and introduced into the Illinois General Assembly in early February remained in the House and Senate Rules Committees as the 1996 spring legislative session came to a close. "Of the numerous managed care bills introduced this spring, the ones that made it to the governor are narrower in scope than MCPRA," said ISMS President Sandra Olson, MD. "The Managed Care Patient Rights Act assures patients the right to quality care and provides for public oversight of care-determining poli-

cies by managed care plans." Because MCPRA is so comprehensive, legislators needed more time to analyze it than the narrower bills, she added.

ISMS will continue fostering discussion and evaluation of MCPRA because of the importance of the issues addressed by the bill, Dr. Olson said. "MCPRA establishes the appropriate balance between the health needs of patients and the financial interests of the insurance companies on which patients rely to finance their care. We were prepared for the prospect that the bill would take more than one session to get legislative approval."

Throughout the session, MCPRA had strong bipartisan support, with more than 30 House and 11 Senate sponsors signing on to the bill. Many expressed a need for legislation that would regulate the managed care industry and, in the process, maintain quality health care for Illinoisans. "I can't
(Continued on page 11)

Update on fraud and abuse

As Illinois Medicine went to press, the AMA reported that House and Senate Republicans had reached agreement in resolving differences on the fraud and abuse language preceding the formal conference committee report on health insurance reform. The conference committee will reconcile the House and Senate reform bills that increase portability and alleviate pre-existing condition exclusions.

The House version, which applied to all health plans, imposed criminal liability on physicians who made inadvertent mistakes in such areas as coding. The new language adopts the "knowing and willful" standard, so that physicians who make innocent errors will not be exposed to criminal liability, according to the AMA.

The original House bill called for civil monetary penalties for Medicare coding mistakes such as upcoding and disagreements over the determination of "medical necessity." In the new language, fines would apply only if physicians demonstrated a "reckless disregard" for the truth in their dealings with Medicare, the AMA reported. The AMA also said it will continue working to change the new provision even though "the potential for the unfair imposition of fines is unlikely."

The agreement limits medical savings accounts to small businesses with 50 or fewer employees and the self-employed. In three years, larger employers would be eligible for the MSA option, according to the AMA.

Watch for your next issue, July 19, for more coverage of this agreement. ■

INSIDE

**ISMS
delegates act
on range of
issues**

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ISMS will fight to preserve cap on noneconomic damages

ANALYSIS: Society, ICJL respond to ruling that cap is unconstitutional. BY KATHLEEN FURORE

[CHICAGO] Despite Cook County Circuit Court Judge Kenneth Gillis' May 22 ruling that declared the 1995 tort reform provision capping noneconomic damage awards at \$500,000 unconstitutional, ISMS is confident other courts "will be more favorable" to the cap, which physicians fought so hard to achieve, said Chairman of the ISMS Board of Trustees M. LeRoy Sprang, MD.

"Keep in mind that this is but one circuit court judge's order, which does not set prece-

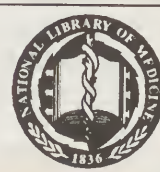
dent and is not legally binding on other judges," Dr. Sprang said. "While significant, this single court ruling in a single locale of Illinois does not represent the court's final word on ISMS' tort reform legislation. Illinois' appellate and state supreme courts are much broader, more legally meaningful and balanced judicial arenas [in which] to evaluate the merits of reform."

"Illinois physicians are deeply disappointed in this trial court decision," said ISMS Pres-

ident Sandra Olson, MD. "[But] ISMS remains confident that upon higher court review, the legislature's farsighted and thoughtful action will ultimately be upheld."

As Dr. Sprang and ISMS General Counsel Saul Morse noted, many of the tort reforms of 1985 and 1987 were also challenged but today prevail as law. "In 1985, [tort reform legislation] abolished punitive damages in malpractice cases and created a statute requiring affidavits of

(Continued on page 2)



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1996 ISMS legislative highlights

Bill	Summary	Outcome	ISMS position
S.B. 1246	Allows women enrolled in managed care plans to select a participating Ob/Gyn as their "principal health care provider" whom they can access without referral or prior approval.	Passed	Supported
H.B. 2557	Requires insurers to pay for at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a cesarean section	Passed	Supported
H.B. 3613	Gives health care workers the option of reporting to law enforcement agencies the blood alcohol and drug test results of emergency department patients injured in motor vehicle accidents.	Passed	Supported
H.B. 3271	Bans ultimate fighting exhibitions in Illinois.	Passed	Supported
H.B. 3618	Consolidates all Good Samaritan immunity provisions contained in other laws governing various professions into one Good Samaritan Act.	Passed	Supported
H.B. 3617	Bans distribution of nonprescribed drugs to people under 18 to stimulate weight gain or loss for athletic competition.	Passed	Supported
H.B. 1249	Provides immunity to health care workers who perform blood alcohol or drug content tests at the request of law enforcement authorities.	Passed	Supported
H.B. 2691	Would have provided immunity from liability for civil damages to volunteers who transport people to or from health care facilities.	Failed	Supported
H.B. 2888	Would have required public restrooms to display hand-washing policy.	Failed	Supported
H.B. 2881	Would have repealed \$500,000 cap on noneconomic damages in medical malpractice suits and other tort cases.	Failed	Opposed
H.B. 2882	Would have repealed tort reform modifications to the Petrillo doctrine. For example, patients who filed malpractice suits would not have been required to authorize release of their medical records to defendants within 28 days.	Failed	Opposed
H.B. 2884	Would have restored pre-tort reform provisions about joint and several liability. For example, physicians could have been liable for all damages, even if they were only partly responsible.	Failed	Opposed

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ISMS will fight

(Continued from page 1)

merit to be filed with all complaints," Morse said. "A Cook County judge held all the 1985 reforms unconstitutional. But the Illinois Supreme Court upheld all of our reforms except one, which would have created screening panels to review cases."

Dr. Sprang stressed that ISMS will mount a "strong and aggressive defense" of the \$500,000 cap. "Rest assured, ISMS will do everything in our power to continue the fight for caps and any other tort reform laws that may be scrutinized by the courts."

GILLIS' DECISION echoed the arguments plaintiffs' attorneys put forth during last year's legislative debate of H.B. 20. Consequently, plaintiffs' attorneys are likely to use the ruling as a guideline in Cook County courts and in other Illinois court jurisdictions, Dr. Sprang said. For example, Gillis said there is "no rational basis for the legislature's limitation on noneconomic damages." He also termed the provision "special legislation" because it applies only to certain classes of damages, and said the cap "presents a more invidious, and secret, way of undermining the right to a jury trial than any heretofore designed." In addition, Gillis wrote that the law violates the separation of powers and the section of the 1970 Illinois Constitution that guarantees remedies in the laws for individuals who are injured or wronged, Gillis wrote.

But Illinois Civil Justice League President Edward Murnane said he firmly believes the \$500,000 cap, as well as all other H.B. 20 provisions, will ultimately survive the constitutional challenge. "Every provision of H.B. 20 was carefully reviewed and analyzed by skilled con-

stitutional lawyers," Murnane said. "We remain convinced that this legislation is not only good legislation enacted in the best interests of all Illinois residents, but that it is clearly constitutional as well."

In fact, Morse said Gillis' decision appeared "to clearly be ignoring the traditional relationship between the legislature and the courts."

"[The decision] says the legislature can't change what has existed in common law," Morse continued. "He is saying the jury is inviolate, when in reality judges change jury decisions and reverse jury verdicts. The Illinois Supreme Court never has gone as far as he did [in this decision]."

Morse also questioned Gillis' ruling that if the Illinois Supreme Court declares the cap constitutional, each family member of a deceased person would have a separate \$500,000 cap. "That defies all of the law on wrongful death that has existed since the Wrongful Death Act was created," Morse said. "As you read the decision, things really look like they won't stand up. It will be a long battle, and this is but one ruling. Now we'll go to a higher court and see what happens."

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Delegates act on range of issues

ACTIONS: Topics include Ob/Gyns as primary care physicians, corporate practice of medicine and defining 'surgery.' BY HELENE BERLIN

[OAK BROOK] The following continues coverage of actions taken by delegates in April at the ISMS Annual Meeting in Oak Brook:

OB/GYNS AS PRIMARY CARE PHYSICIANS

A resolution that prompted lengthy discussion called for ISMS to support women's choice of Ob/Gyns as their primary care physicians. Delegates favored the concept but ultimately rejected the resolution to reaffirm one approved last year that does not specifically refer to Ob/Gyns as primary care physicians.

A rationale for this year's resolution was that gynecological concerns often introduce medical care to women, who may not know any physicians except their Ob/Gyns. A supporter of the resolution said more than half of American women seek primary care from their Ob/Gyns. Opponents said parallel arguments could be made for specialists like cardiologists and endocrinologists.

The reaffirmed resolution asks the Society to "promote state legislation to allow obstetricians and gynecologists direct access to patients for their initial health care contact."

FINANCIAL INCENTIVES AND PATIENT CARE

Noting that economic incentives may pose a potential conflict of interest for physicians if those incentives interfere with patients' interests, a reference committee proposed to amend the Medical Practice Act to ban payments, inducements or any incentive arrangements with third parties that conflict with physicians' fiduciary obligations to patients. It also suggested authorizing the Medical Disciplinary Board to enjoin any third-party payment or incentives to physicians if these arrangements conflict with physicians' fiduciary duty to patients.

Delegates discussed a substitute resolution calling for full disclosure of, rather than an outright ban on, incentive arrangements. Ultimately, both resolutions were referred to the Board of Trustees for decision, since the Board will discuss potential changes to the Medical Practice Act, which sunsets in 1997.

HOSPITALS' PRACTICE OF MEDICINE

The House considered a resolution that ISMS promote legislation to protect fair market opportunities for tax-paying physicians in private practice who face unfair competition from tax-exempt or not-for-profit health care delivery entities. Delegates found the resolution identical to one from 1995 that is being reviewed by the Council on Economics, so no further action was taken.

In the reference committee and on the House floor, discussion centered on the unfair competitive advantage tax-exempt hospitals have if allowed to practice medicine in the same market with tax-paying physician practices. Delegates alluded to the case of Dr. Richard Berlin and Sarah Bush Lincoln Health Center. In that case, an appeals court recently held that the health center could not enforce an employment contract with a physician, because under the Medical Practice Act, hospitals are licensed as not-for-profit corporations that cannot engage in medical

practice. The health center planned an appeal to the Illinois Supreme Court.

DEFINITION OF SURGERY

Delegates considered a resolution to adopt as policy a comprehensive definition of surgery that would cover such invasive procedures as photorefractive keratectomy. The House voted to refer the resolution to the Board of Trustees for decision.

The definition addressed the application of extreme cold, sonic waves, laser energy, chemical cautery or ionizing radiation or any other invasive procedure in which tissue is cut, burned, frozen, vaporized, disrupted or otherwise physically altered.

RECONSTITUTING MEDICAL DISCIPLINARY BOARD

For the second consecutive year, the independence of the Illinois Medical Disciplinary Board was a topic of vigorous discussion. The 1996 resolution referred to the IMDB as primarily an advisory board to the Illinois Department of Professional Regulation, with "no indepen-

dent or autonomous authority to enjoin unethical or unprofessional conduct by physicians." It recommended that ISMS develop legislation amending the Medical Practice Act to make the IMDB an independent, authoritative board.

The resolution was not adopted. Instead, delegates adopted an unfinished business report generated by the Board of Trustees as a result of a 1995 resolution. The report references nonpolitical guidelines for recommending physicians for the Illinois Medical Disciplinary Board and Medical Licensing Board. The guidelines had been approved by the ISMS Board. ■



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REPORT for Illinois Physicians

MEDICARE

MEDICARE COVERAGE OF DIAGNOSTIC PAP SMEARS

A diagnostic pap smear is a laboratory study involving the collection and microscopic analysis of cells from the cervix and vagina for the early detection of cancer. A diagnostic pap smear and related medically necessary services are covered under Medicare Part B when ordered by a physician under one of the following conditions:

1. Previous cancer of the cervix, uterus, vagina that has been or is presently being treated;
2. Previous abnormal pap smear.

The specific conditions for which a diagnostic pap smear are covered include: any abnormal findings of the vagina, cervix, uterus, ovaries, or adnexa; any significant complaint by the patient referable to the female reproductive system; or any signs or symptoms that might in the physician's judgment reasonably be related to a gynecological disorder.

Documentation is required only when submitting a claim with a diagnosis not listed in the covered ICD-9-CM codes. Suggested documentation would include physician progress notes with pertinent medical history, physical examination findings and laboratory results.

Beginning with dates of service on and after July 15, 1996, submission of a claim to Medicare for diagnostic pap smear with other than a covered ICD-9-CM code will be denied without supporting documentation.

Health Care Service Corporation, a Mutual Legal Reserve Company
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EDITORIAL

Finding perspective in tort reform

Perspective can be elusive in life and in that reflection of life events – the media. In announcing the Cook County Circuit Court judge's ruling that our state's \$500,000 cap on noneconomic damages in tort cases is unconstitutional, some news headlines were categorical. But let's keep that decision in perspective.

Last year at this time, we were still celebrating the enactment of a comprehensive tort reform bill that included the cap. We had reason to celebrate after winning a long, tough fight. But even then, we figured that any hard-won victory would probably require a struggle to sustain. The fight has continued, and we're in the middle of it.

As a sponsor of the tort reform bill, Sen. Kirk Dillard, put it in the Daily Herald, "It's just the first inning of a nine-inning ball game. I think it's the role of the legislature to determine public policy."

A spokesperson for another sponsor, House Speaker Lee Daniels, said, "This was landmark legislation that passed last year, and we don't expect it to end here," reported the Chicago Daily Law Bulletin.

To help place Judge Kenneth Gillis' ruling in perspective, the front page of this issue includes a story that outlines – and counters – some of his arguments. For instance, the analysis questions the premise that the new law intrudes into

the province of juries, which is inviolate. The reality is that judges regularly change jury decisions and reverse jury verdicts.

This decision constitutes just one circuit court judge's opinion. It doesn't set precedent, and it isn't legally binding on other judges. Other provisions of the law have been challenged in several Illinois courts with judges offering varying opinions. The Illinois Supreme Court will probably give the final word on the cap and the other reforms enacted last year.

Meanwhile, though, will the ammunition keep flying? You bet. Past-president of the Illinois Trial Lawyers Association Curt Rodin was quoted in the Bulletin as saying, "We recognize [the decision] is just a first step. We are by no means going to rest on our laurels."

Opponents of tort reform haven't rested at all, as substantiated by the feature story and the scorecard in this issue. During the spring legislative session, several bills were introduced into the General Assembly that would have reversed specific provisions of the law – for instance, the cap and reforms to the Petrillo doctrine and joint and several liability. But the Society opposed the bills, and they were defeated.

ISMS, along with the Illinois Civil Justice League, will do everything possible to continue the fight for caps and for the other tort reforms we won last year. ■

PRESIDENT'S LETTER

Legal illogic

Sandra F. Olson, MD



After all, the cost of unrestrained damage awards is taxed to everyone.

The recent Cook County Circuit Court ruling that caps on noneconomic damages are unconstitutional and invalid is disappointing, to say the least, but not surprising. The road to tort reform is bumpy and booby-trapped, but must be taken one step at a time. It's important that we keep this decision in perspective. It is not binding on other judges in this or other circuit courts, but there is no question it may influence some judges when they rule on related cases.

The opinion was issued in an action that consolidated six personal injury lawsuits and addressed only the constitutionality of H.B. 20, which was passed on March 9, 1995, and imposed caps on punitive damages at \$500,000 in personal injury lawsuits. The judge's reasoning as to why caps are unconstitutional is very interesting and puzzling – to this nonlawyer. He opines, among other points, that it is illegal to place a ceiling on noneconomic damages in personal injury cases and not on other types of cases, such as those brought by businesses. He also says economic damages, such as medical costs, lost wages, etc., are speculative and as inexact as noneconomic damages. He supports this point by citing the possibility of potential downsizing by a plaintiff's employer, thereby affecting the amount of future wages calculated in such a settlement. True, but at least there is some quantifiable objectivity in economic damages. But noneconomic losses, such as loss of companionship or consortium, pain and suffering, etc., are purely speculative and subjective, and based on emotional factors. These latter are incalculable and vary by case, and clearly are able to sway sympathetic jurors. What is puzzling is equating the two types of damages, basically calling both inestimable. Then why do we bother at all? Why not just set up some sort of damages scale or formula to compensate everyone who has had an injury and establish a no-fault system?

Another twist on this decision is the fact it negates a law duly passed by our General Assembly that represents the citizens of our state. As stated in a Chicago Tribune editorial dated June 4, "Americans have long had the sense that their liability system is out of control, often capriciously awarding large amounts of money to people who deserve small amounts – or none at all." Is it the will of the citizens of Illinois to be written off so cavalierly? Public opinion research has repeatedly demonstrated support for caps by almost three-quarters of the voters in Illinois. Doesn't that speak for ending this lotto mentality that has taken hold of our tort system?

Judge Gillis also states that this law infringes on the right to a jury trial because it limits a jury's right to set awards. Citizens make laws by speaking through their legislative representatives. Why shouldn't such rules bind juries? Aren't there other restrictions on juries? Judge Gillis said there is a safeguard because judges can reduce excessive awards on a discretionary basis. Can't the people speak through our legislatures to this issue? After all, the cost of unrestrained damage awards is taxed to everyone.

In contrast, a U.S. Supreme Court decision almost simultaneously held that a \$2 million award to a BMW owner for a flawed paint job was grossly excessive. The court says that such awards should not be "grossly out of proportion to the severity of the offence." Where was the reduction to a reasonable amount by the trial judge? In his opinion, Justice John Paul Stephens wrote that one point to consider in determining awards is a comparison of jury awards with the civil awards that result from actionable conduct as defined by state legislatures or awards imposed in comparable cases. The federal court decision did not impose a limit, but remanded the case to Alabama for settlement or retrial.

So where are we? Not a step farther, but this journey will continue. ■

GUEST EDITORIAL

If you are really sick, please don't stop by

By Joan Beck

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It's instructive that last week's news about the mega-merger that is creating the nation's largest managed health care corporation was reported most often on newspapers' financial pages. Never mind that the merger will affect the health of 23 million people — one in every 12 Americans. What counts is what happened to the prices of the companies' stock and big payoffs for the corporate players.

Health care in America is fast becoming a matter of stock prices, CEOs' salaries, cost savings and cutbacks — not new cancer therapies, breakthrough drugs or new help for intractable diseases. Its heroes and role models aren't the white-coated scientists who discover new cures but the suits who put together the big deals, not the physicians who save lives but the corporate honchos who cut health care jobs and find innovative ways to deny treatment.

In the newest deal, Aetna Life & Casualty Co. is acquiring U.S. Healthcare Inc. for about \$8.9 billion in cash and stock. Aetna is an old-line insurance company moving rapidly into managed health care, which it sees as the big financial game of the future.

Its new acquisition is a managed care corporation with a reputation for tightly controlling costs — and the doctors who work for it. Reports say U.S. Healthcare spends only 75 cents of every dollar it is paid in premiums for medical care, compared to an industry average of 81 cents and Aetna's 85 cents. U.S. Healthcare has administrative costs of 14.5 cents on the dollar (Medicare's are 2 cents); 10.5 cents go for profit.

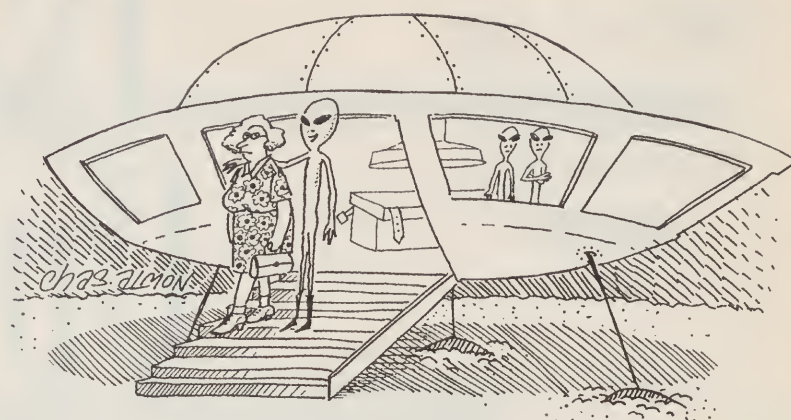
What has shocked and angered patients and health care professionals is the report that Leonard Abramson, founder and chairman of U.S. Healthcare, will get almost \$1 billion in stock and cash from the deal. Think how many nurses that would keep on the job, how much life-saving drug research that would finance, how many specialists that would train.

In a time when many HMOs are denying bone marrow transplants to cancer patients, limiting hospitalizations and referrals to specialists, forcing mothers out of the hospital 24 hours after giving birth and refusing to OK some expensive medications, tests and treatments, such a financial windfall seems obscene, however the merger game is played.

"What Aetna is getting for this immense sum is not hospitals, clinics or other tangible facilities, but the exclusive right to control and profit from the relationship between patients and the health system," points out the nonprofit Physicians for a National Health Program. "U.S. Healthcare rewards doctors for giving skimpy care and penalizes them for referring patients to specialists, emergency rooms or hospitals."

This won't be the last of the big health care mergers. There are almost 600 managed care corporations now operating in the United States, most of them vulnerable to the merger mania and cost-cutting mentality. Fifty-four percent of physicians already work for or with HMOs. Most of the rest fear they will have to if they want patients.

Millions more Americans will be pushed into managed care organizations of various types in the next few years. Many of them will be vulnerable to a



"If you have any complications, take two aspirin and call a tabloid journalist in the morning."

pattern of abuses that is emerging as health care becomes just another business opportunity for investors and executives, and doctors are being told, in essence, to put up or shut up.

Costs are being wrung out of health care. But much of the savings is going to new layers of corporate executives and administrators, to stockholders and the merger-makers who might as well be dealing with widgets as with people's lives and health.

To get away with curtailing high-tech and expensive care, some HMOs force physicians to sign agreements that contain "gag" orders forbidding them to tell patients about treatments or referrals to specialists the HMO will not provide, even though they might be successful. The AMA calls gag orders "unethical" and "harmful to patients."

Other gag orders forbid doctors from telling patients how they are paid, especially if they are financially penalized for referrals or hospitalizations or high-tech procedures they prescribe.

Even some emerging remedies are worrisome. For example, state legislatures are hurrying to pass laws to give more protection to HMO patients. Two states have made gag rules illegal, and several others are considering such laws. Many states now require HMOs to pay for two days of hospital care for mothers

after childbirth, instead of pushing them out in half that time.

But this process is a slow and difficult way to assure patients will get the necessary care they used to take for granted. And it's troubling that there seems to be a need for legislators to intervene in what should be private, professional relationships between patient and doctor.

Lawsuits are another weapon against HMOs that harm or endanger patients by undertreatment. But they may not prevent damage to lives and health. They are cumbersome, drawn-out, iffy. And they add to the total cost of health care in nonproductive ways.

The federal government is planning to relax some of the restrictions that have made it difficult for doctors to set up their own cooperative groups and managed care organizations. Doctors are already beginning to develop networks and coalitions and to contract with employers to deliver health care directly to workers. If physicians can act fast enough, they may be able to slow the fast-moving sweep of people into for-profit, business-oriented managed care.

American health care has long been the best in the world. But it is now rushing into unknown territory propelled by forces that may dumb it down, reduce it and do it damage. None of us can afford to let that happen. ■

Don't forget to renew your license

Illinois physicians, beware. Your three-year medical and controlled substance licenses expire July 31. Physicians who do not renew their licenses by the deadline will be technically practicing without a license and could face disciplinary action by the Illinois State Medical Disciplinary Board. ISMIE policyholders who fail to renew will also lose their medical malpractice coverage for the period of time they practice without a valid license.

The Illinois Department of Professional Regulation mailed renewal packets to all Illinois physicians in early June. Any physician who has not received renewal forms by late June should contact IDPR at (217) 782-0458. ■



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ISMIE Update

Three Texas med mal insurers appeal denial of rate hikes

HEARINGS: Action follows insurance commissioner's rejection of increases filed by four carriers. BY KATHLEEN FUREORE

[AUSTIN, TEXAS] This month, three medical professional liability insurers in Texas – Medical Protective Co., Continental Casualty Co. and American Casualty Co. – are scheduled to appeal the Texas insurance commissioner's decision to reject their proposed

rate increases, according to a spokesperson for the Texas Department of Insurance. The hearings will be held before the State Office of Hearings Examiners, and the commissioner will make a final decision after reviewing the administrative law judges' recommendations, a

TDI spokesperson said. Texas Insurance Commissioner Elton Bomer made his decision in March to reject rate hikes submitted by four insurers. The increases "would have been passed down from physicians to consumers, raising again the cost of health care for patients

and employees," Bomer said.

The insurers were the American Physicians Insurance Exchange of Austin, Texas; Medical Protective Co. of Fort Wayne, Ind.; Continental Casualty Co. of Chicago; and American Casualty Co. of Reading, Pa. Those four companies account for some 45 percent of the regulated medical professional liability insurance market in Texas. Medical Protective Co. sought to boost rates by 22 percent, and Continental and American Casualty – both units of CNA Insurance – each requested a 45 percent rate hike, according to TDI data.

About one month after Bomer's decision, APIE withdrew its request to raise its rates in Texas by 32 percent and agreed to leave its current rates in effect for two more years, according to information from TDI. The company is the third largest medical malpractice writer in Texas with \$27.5 million in premiums and 11.3 percent of the market share.

Bomer said he rejected the filed increases after actuaries indicated the hikes "would result in overcharging Texas doctors for this essential [medical malpractice] coverage." All four companies were also charged with overestimating future claims. "State law charges me with examining medical malpractice rates in Texas and making sure they are adequate, reasonable, not excessive and not unfairly discriminatory," he explained.

In 1993, the Texas legislature enacted a file-and-use system that lets insurers set their own medical malpractice rates based on such factors as their loss experience. Bomer was the first commissioner to reject rate hikes under that system, TDI information said.

The Illinois Insurance Code gives the director of the Illinois Department of Insurance the right to reject medical malpractice rates filed by insurers, according to IDOI spokesperson Nan Nesis. "But if a rate is deemed excessive or unreasonable, there would be a hearing. Depending on the outcome of that hearing, the director would make a ruling," Nesis said. She added, however, that the department rejected a proposed rate increase only once. "That was in the late '70s. But there was a hearing, and the rate [increase] was upheld."

ISMIE has no plans to raise premiums for specialties in the upcoming policy year, said Alfred Clementi, MD, chairman of the ISMIS Board of Directors. In fact, premiums will decrease for gynecological surgeons, hand surgeons and anesthesiologists. ISMIE intends to keep its surplus at the minimum required by the IDOI, which will help keep policyholders' rates as low as possible. The insurer can do that because it expects the frequency and severity of losses to improve as a result of tort reform and risk management efforts, Dr. Clementi said.

MALPRACTICE ROUNDUP

Terminated physician sues medical group

In a case that challenges a bottom line mentality for medical groups, a pediatric gastroenterologist has filed a \$1 million lawsuit in San Diego's Superior Court charging that the Children's Associated Medical Group Inc. fired him for spending too much time with patients. Thomas Self, MD, also contends that the group, which staffs San Diego's Children's Hospital, terminated him for ordering too many expensive tests, according to a case summary in the January 1996 issue of National Health Lawyers News Report.

Dr. Self, who formerly headed Children's pediatric gastroenterology department, charges that the physician who took his place caused the death of a teen-ager during endoscopy and injured two other children. The medical group's president has disputed Dr. Self's allegations, according to the story.

Stroke victim's physician met standard of care

A California jury found that a defendant physician who failed to diagnose a patient's stroke acted within the standard of care, according to a case summary in the February 1996 issue of Medical Malpractice Law & Strategy.

Although the plaintiff in Viramontes vs. Ruiz had a history of hypertension and had been vomiting for four days, his temperature was the only vital sign taken when he presented at a walk-in clinic. He returned home after the defendant physician diagnosed gastritis. The next day, the plaintiff suffered a hemorrhagic stroke that caused permanent hemiparesis and visual problems. His blood pressure was extremely high the day he experienced the stroke, the story noted.

In the suit, the plaintiff alleged that the stroke could have been prevented if his blood pressure had been taken on his first clinic visit. But the physician said the stroke probably caused the vomiting, which meant the patient had already suffered the stroke before he presented at the clinic. The doctor contended, and the jury agreed, that the standard of care did not require taking a patient's blood pressure if that patient presented with vomiting absent any other symptoms, the case summary said.

Physicians not liable for woman's stroke

A Chicago jury cleared three physicians of liability in a lawsuit charging that the angiograms they ordered caused two strokes in a woman who had suffered a transient ischemic attack, according to a report in the May 27 National Law Journal.

After the plaintiff's ministroke, an ultrasound of her left carotid artery found it nearly blocked. Physicians then ordered an angiogram, and less than 24 hours after undergoing the test, the patient suffered a severe stroke. A few weeks and another ultrasound later, doctors ordered a second angiogram. Six hours after that procedure, the plaintiff had another stroke that left her aphasic and confined to a wheelchair. The doctors said both angiograms were necessary to properly diagnose her carotid artery blockage.

The Circuit Court of Cook County jury ruled for the defendants on April 24.



John McNulty

"I'LL TRADE YOU two cookies for a bag of chips." ISMS delegates share the contents of their box lunches at the April 20 ISMIE luncheon at the Annual Meeting in Oak Brook.

ISMS victories highlight spring legislative session

Lawmakers pass bills that eliminate drive-through deliveries and let managed care patients choose Ob/Gyns as primary care physicians.

BY KATHLEEN FURORE



Photos: Ron Ackerman

The spring 1996 legislative session, which adjourned May 25, reflected constituents' interest in emerging managed care issues. ISMS' Managed Care Patient Rights Act aimed to help preserve the physician-patient relationship in the face of possible conflicts of interest posed by insurers. Because of the comprehensiveness of the measure, the Society anticipated a tough battle even though the bill had strong bipartisan support and sponsorship. In the end, MCPRA did not progress this session, but it will be reviewed and reintroduced.

A more narrowly focused managed care bill that was developed by House Republicans did, however, pass the House and the Senate and is on Gov. Jim Edgar's desk. Under S.B. 1246, which was supported by ISMS, women whose health care plans require them to choose a coordinating physician can select a participating "woman's principal health care provider" whom they can access without referral or prior approval. The legislation defines that provider as "a physician licensed to practice medicine in all of its branches specializing in obstetrics or gynecology." Sponsored by Sen. Laura Kent Donahue (R-Quincy) and Rep. Rosemary Mulligan (R-Des Plaines), the measure received overwhelming support in both the House and Senate.

"I'm really excited that this bill passed," Mulligan said. "It is an important piece of legislation because it allows women access, without waiting for a referral, to providers they normally would go to for a good part of their adult lives. It is an opening to examine ways to provide managed care but to still access appropriate services that meet the needs of individual patients."

The legislation is also important in that it defines two key managed care terms for the first time. A managed care entity is "any entity including a licensed insurance company, hospital or medical service plan, health maintenance organization, preferred provider organization, third-party administrator, an employer

or employee organization, or any person or entity that establishes, operates, or maintains a network of participating providers." A managed care plan is "operated by a managed care entity that provides for the financing of health care services to persons enrolled in the plan through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution; or financial incentives for persons enrolled in the plan to use the participating providers and procedures covered by the plan."

By defining those terms and attempting to address ERISA-exempt employee or employer organizations in S.B. 1246, legislators have for the first time attempted to impose meaningful regulation on managed care plans, said Chairman of the ISMS Board of Trustees M. LeRoy Sprang, MD.

Another managed care bill on Edgar's desk is H.B. 2557, sponsored by Rep. Kay Wojcik (R-Schaumburg) and Sen. Robert Madigan (R-Lincoln). The measure, which garnered strong bipartisan support, requires insurers to pay for at least 48 hours of inpatient care following a vaginal delivery and 96 hours of inpatient care following a birth by cesarean section. It also allows for earlier discharge when attending physicians decide a shorter stay would not pose a risk to mothers or infants. Such a determination must be made in accordance with protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Insurers will be required to cover mothers and infants who see their physicians or receive home visits by nurses within the first 48 hours of an early discharge.

Wojcik said she was "absolutely elated" after H.B. 2557 passed the House and Senate. "This has been a long time in coming. Giving birth is a beautiful experience, and women shouldn't have to be watching the clock. This also puts less pressure on physicians to get the female out of the hospital."

In addition to acting on managed care, legislators

(Continued on page 8)

ISMS victories

(Continued from page 7)

passed the following health care-related bills that reflect or relate to ISMS policy and positions.

REPORTING ALCOHOL AND DRUG LEVELS

A bill that mirrors policy adopted this year by the ISMS House of Delegates is on the governor's desk after being amended by the Senate and receiving concurrence by the House. Rep. David Winters (R-Rockford) and Sen. J. Bradley Burzynski (R-Sycamore) sponsored H.B. 3613, which gives health care workers the option of reporting to law enforcement agencies the blood alcohol and drug test results of emergency department patients injured in motor vehicle accidents. That reporting would not result in civil liability or professional discipline except in the case of willful or wanton misconduct.

BLOOD AND URINE COLLECTION

The legislature also sent Edgar H.B. 1249, an ISMS-backed bill that amends the Vehicle Code's driving-while-intoxicated provisions. The measure grants immunity from civil liability to people authorized to withdraw blood or collect urine for evidentiary purposes at a law enforcement officer's request. The only exception would be if the act was performed in a willful or wanton manner. Sen. Edward Petka (R-Plainfield) and Sen. Carl Hawkinson (R-Galesburg) sponsored the bill.

ULTIMATE FIGHTING

H.B. 3271, which bans ultimate fighting exhibitions in Illinois, reached Edgar's desk this year. The bill was sponsored by Rep. James Meyer (R-Bolingbrook) and Sen. William Peterson (R-Prairie View) and is consistent with a position the ISMS House of Delegates adopted at the Society's Annual Meeting in April.



GOOD SAMARITAN COVERAGE

Both the House and Senate approved H.B. 3618, which consolidates all Good Samaritan immunity provisions contained in other laws governing various professions and activities into one Good Samaritan Act. Winters and Burzynski sponsored the measure, and ISMS supported it.

The Illinois State Bar Association and the trial lawyers successfully blocked H.B. 2691, which sought to provide immunity from liability for civil damages to volunteers who transport people to or from a health care facility or service unless those volunteers' acts or omissions constitute willful or wanton misconduct. H.B. 2691 mirrored an ISMS HOD position that the Society "seek to have legislation introduced in the General Assembly that would extend the state's Good Samaritan Act so as to provide protection from civil liability to unpaid volunteers acting appropriately, without malice, engaged in the transport of patients to facilitate health care." Rep. Carolyn Krause (R-Mt. Prospect) and Sen. Dave Syverson (R-Rockford) sponsored the measure.

ATHLETES AND DRUGS

The House and Senate passed H.B. 3617, sponsored by Rep. Anne Zickus (R-Palos Hills) and Sen. Robert Raica (R-LaGrange). Under the measure, anyone distributing a nonprescribed drug to a person under 18 to stimulate weight gain or loss for athletic competition is guilty of the offense of drug-induced infliction of aggravated battery to a child athlete. The final version of H.B. 3617 included an ISMS-proposed amendment clarifying that the offense does not apply to licensed physicians who distribute such drugs under their usual and customary standards or to retail merchants selling over-the-counter products.

HAND-WASHING NOTICES

H.B. 2828, sponsored by Rep. Edgar Lopez (D-Chicago), would have required public restrooms to display a hand-washing notice. The measure failed to emerge from the House Consumer Protection Committee. The bill was in line with the ISMS HOD position that the Society should initiate, encourage and support legislation mandating signs in public restrooms to help prevent the spread of disease.

OPPOSITION TO TORT REFORM

Several bills failed that sought to nullify provisions in last year's tort reform law. H.B. 2881 would have repealed the \$500,000 cap on noneconomic damages in medical malpractice lawsuits and other tort cases. H.B. 2882 would have reversed changes to the Petrillo doctrine. For example, patients who filed malpractice suits would not have been required to authorize release of their medical records to defendants within 28 days. And H.B. 2884 would have restored pre-tort reform law governing joint and several liability. So, physicians could have been liable for all damages in a suit even if they were only partly responsible. ISMS opposed all three bills. ■

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MCPRA to continue

(Continued from page 1)

think of a more important public policy right now than that of patient rights with respect to managed care," said Rep. Tom Cross (R-Yorkville), a lead sponsor of the bill.

Rep. Penny Severns (D-Decatur) applauded ISMS for "taking the initiative to advance a plan that is geared toward patient rights and that guarantees patients a right, in consultation with their physician, to make decisions in the best interests of their health." Severns, a breast cancer patient, said she selected her health care plan based solely on which one would let her continue with her treating physician.

MCPRA is important because it will return health care delivery to a patient-centered system in which health care decisions are between physicians and patients, not insurance executives, said Rep. Judy Erwin (D-Chicago). "There hasn't been a member of the General Assembly who hasn't had a family member, friend or constituent complain about being denied access to a medical procedure they should have."

CROSS SAID he's confident MCPRA – or a version of it – will see action this fall or during the next legislative session. "I think the outlook is good. My colleagues are conscious of the problems of HMOs and the fact that we need to address them. This is not going to go away. It is

too important an issue, and there are too many abuses."

A managed care bill that did pass the General Assembly this session establishes mandatory minimum maternity benefits that echo those MCPRA proposed. H.B. 2557 requires at least 48 hours of inpatient care following a vaginal delivery and 96 hours after a cesarean section. In addition, legislators passed S.B. 1246, which allows women in managed care plans to choose Ob/Gyns as "principal health care providers" whom they can access without referral or prior approval. The fact that these bills passed shows that legislators believe there is a need to regulate managed care, Cross said.

Securing passage of MCPRA, however, "could take some time and effort," Cross noted. But he said he doubts the process will be as drawn out as was the battle for tort reform. "This is very complex. But so many people on both sides of the aisle either have had personal experiences with or have constituents who have had problems with managed care that this will probably have a shorter life than tort reform."

Specifically, MCPRA seeks to provide patients with quality health care services from their health insurance plans, the freedom to choose the physician who will coordinate their health care and confidence that their providers will be able to freely advocate on their behalf for medically necessary health care. In addition, the bill says patients are enti-

tled to receive clear and understandable information about the terms and conditions of managed care plans and health insurance as well as information on managed care plans' performance in providing quality care.

Also listed as basic rights are mandatory minimum maternity benefits, privacy and confidentiality in the use of health care services, knowledge of the identity of the patient's participating providers, a

reasonable explanation of bills for services, freedom to purchase noncovered health care services, protection from revocation of managed care authorization given in advance of the patient's treatment, prohibition of prior authorization requirements for emergency care, and timely and clear notification when a managed care plan terminates the patient's coverage or terminates the patient's provider from the plan. ■

State budget

(Continued from page 1)

appropriation also contains a \$699,200 cut for certain services to individuals who previously qualified for IDPA disability coverage as a result of substance abuse, he noted.

THE MEDICAID physician payment cycle has been less than 30 days for the past several months. Although IDPA projects an overall payment cycle of 37 days for FY '97, the cycle could be considerably less. "From the physician standpoint, the payment cycle, which already has been shortened, will remain the same or become even shorter," Dr. Schneider said. Payment cycles in previous years have reached 69 days.

The newly approved budget also provides for a 6.8 percent payment increase for long-term-care providers, effective Jan. 1, 1997, which will be partly funded by the continuation of the assessment tax

on long-term-care facilities. The budget also reflects a 3 percent rate increase for noninstitutional providers such as optometrists, podiatrists and chiropractors, effective July 1, 1996, and a \$400,000 addition to the dental line for a new emergency care dental program.

Hospitals will not receive rate increases, the analyst noted. However, \$6.8 million has been added to the budget for a payment rate add-on for Downstate hospitals. These funds will help offset the FY '96 hospital payment rate decrease that was balanced for most hospitals by a cut in the hospital assessment tax that helps fund Medicaid. Last fiscal year, smaller Downstate hospitals were exempted from the tax and received a rate cut. The tax will be eliminated by July 1, 1997.

IDPA is also budgeting an increase in HMO enrollment from 170,000 to 210,000 next year, the analyst said. HMO services are expected to be paid in the month the services are rendered. ■

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ENTIALITY ACT RAISES LIABILITY ISSUES (PAGE 9)



Hospice offers
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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JULY 19 1996

Study shows
doctors
accepting more
financial risk

PAGE 4

ISMS kicks off statewide meetings on Illinois Medical PSO

MANAGED CARE: Physicians will discuss how colleagues can benefit from new organization's services and support. BY KATHLEEN FUREORE

[CHICAGO] In mid-July, ISMS and the Illinois Medical Physician Services Organization launched a series of statewide meetings to explain how the Illinois Medical PSO, developed by ISMS, will benefit Illinois physicians. Program speakers include members of the ISMS Board of Trustees and the Illinois Medical PSO Board of Directors. Meetings are scheduled for July 23 in Sangamon County, July 24 in Madison

County, July 30 in Rock Island County and Aug. 14 in Winnebago County. The county medical societies in those areas are working with ISMS on the programs.

The series underscores ISMS' commitment to the Illinois Medical PSO, an independent for-profit corporation dedicated to providing solo practitioners as well as physicians in group practices with support and services in negotiation and con-

tracting, practice development, managed care operations, administrative and financial planning, and capital formation, said Edward Fesco, MD, chairman of the Illinois Medical PSO Board of Directors.

"ISMS and the Board of Trustees recognized that with all the changes in the medical environment, other entities are playing a greater role in the control of health care," said M. LeRoy Sprang, MD, a member of the Illinois Medical PSO Board. "We were looking for ways [physicians could] retain or regain control." After careful review, ISMS and the trustees decided the best way to achieve that goal was to create the Illinois Medical PSO as a separate entity from ISMS, he said. "This is a bold move for ISMS. At a time when all things around us are changing, ISMS was willing to grab the bull by the horns and pull it to the ground."

(Continued on page 17)

Take charge, experts advise

PROGRAM: Physicians should organize, accept risk and control information. BY JANICE ROSENBERG

[ELGIN] If physicians work together to create well-run physician organizations, they'll greatly improve their ability to control managed care locally, according to speakers at a June 26 meeting of the Sherman-Saint Joseph CME Consortium held at Sherman Hospital in Elgin. The speakers challenged physician members of the medical staffs at Sherman and Saint Joseph hospitals to trade some of their individual autonomy for the collective independence of the medical profession.

"Providers of care - physicians and hospitals - are realizing that to reassert their control over health care, they must organize," said John Ray, interim chief operating officer of the Illinois Medical Physician Services Organization, developed by ISMS.

Physicians didn't need to organize in the era of fee for service, when a network of community hospitals and small physician practices was the perfect "cottage industry," said Ray, who is also president of the Clearwater Group in Los Gatos, Calif. But to succeed under the economics of managed care, physicians must be able to organize, accept financial risk and

control financial and clinical information, he added.

Consolidation is directly stimulated by the presence of managed care organizations in a community, according to Searle Turner, MD, a pediatrician and health care expert with Professional Health Consulting Group, in Del Mar, Calif. "Society has stated that medical care costs too much and has decided that managed care is the way to control health care costs. Now the challenge to us as physicians, hospital board members and members of the community in general is to figure out how to do it."

(Continued on page 19)



Kyung Koo, MD, listens to advice on successful organization.

Joel Lerner

INSIDE

IDPH honors
resident for
helping victim of
auto accident



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Brian Waring

A PANEL of local and national emergency management experts discusses plans to avoid a heat-related crisis like the one that claimed 733 lives in Chicago last year. At the June 21 Chicago program sponsored by MedicAlert, panelists included Edmund Donoghue Jr., MD, Cook County chief medical examiner and ISMS Third District trustee (from left); Teresita Hogan, MD; Barbara Nichols, RN; and Susan Cahn.

IDPA informs Medicaid enrollees about managed care choices

PROGRAMS: Health benefit reps and a hot line aim to curb marketing abuses. BY KATHLEEN FUREORE

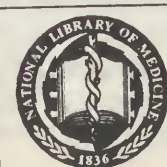
[SPRINGFIELD] To inform public aid recipients about their health care options, the Illinois Department of Public Aid has stationed 85 independent health benefit representatives in all 24 Chicago-area public aid offices. The representatives are available to discuss managed care and fee for service with enrollees in the Aid to Families with Dependent Children program, according to IDPA spokesperson Dean Schott. A letter explaining the program to all recipients was sent in early July. Recipients can currently choose an HMO or fee-for-service provider, and although they will still have those choices under the MediPlan Plus program, HMO enrollment is expected to increase when the program is implemented. Gov. Jim Edgar announced July 12 that the waiver allowing for imple-

mentation of MediPlan Plus had been approved by the U.S. Health Care Financing Administration.

IDPA began its education initiative in mid-February. The reps were recruited, hired and trained under a contract between IDPA and two social service agencies - the Human Resources Development Institute Inc. and the Westside Health Partnership. "The reps explain managed care and fee for service to new clients, and tell them what [HMO] marketing practices are acceptable and what they should do if they have a complaint or question," Schott said. All AFDC recipients, whether long-term or new, can call or walk into a public aid office to ask questions or voice a complaint, he said.

(Continued on page 18)

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Judge rules in corporate practice of medicine case

[ROCKFORD] On June 7, Winnebago County Associate Judge Gerald Grubb granted summary judgment to John Holden, MD, a Rockford reproductive endocrinologist who filed suit against Rockford Memorial Hospital because of a noncompete clause in his employment contract with the hospital. The contract, which Dr. Holden signed in May 1993, specified that he practice medicine exclusively and solely for the hospital.

The contract stated, "In the event this employment agreement is terminated for any reason (or expires), whether during or at the conclusion of the term of this agreement, the physician shall, for a period of two years after termination or expiration date, be barred from practicing reproductive endocrinology in the following counties of the Hospital's service area." Those counties included Rock County in Wisconsin and Winnebago, Boone, Ogle, Whiteside, Lee, DeKalb, McHenry, Stephenson and Kane counties in Illinois.

In Dr. Holden's motion for summary judgment, he contended the hospital "has no authority to practice medicine, no authority to employ physicians and, thus, the noncompetition clause in the employment agreement is unenforceable."

Rockford Memorial Hospital has not decided if it will appeal the case, and the hospital has no comment on the ruling at this time, according to a hospital spokesperson. Dr. Holden's attorney,

Richard Haldeman, was out of town and could not be reached for comment before this issue went to press.

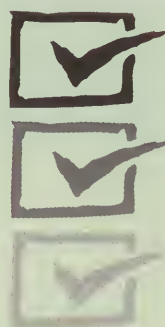
The case mirrors that of Richard Berlin Jr., MD, the general surgeon who sued Sarah Bush Lincoln Health Center in Charleston over a similar noncompete clause in an employment contract. In 1995, the Circuit Court of Coles County ruled Dr. Berlin's contract with the health center unenforceable because the center is licensed as a not-for-profit corporation and cannot engage in medical practice. Such practice, the trial court noted, violates the Medical Practice Act, which specifies that only individuals licensed to practice medicine may do so. The Fourth District Appellate Court upheld the lower court's ruling on April 12.

Watch for a detailed account of Dr. Holden's case in an upcoming issue of Illinois Medicine. ■



Vince Pierri

ISMS ALLIANCE MEMBER Anne Ring chats with a resident of Winchester House nursing home in Libertyville. Ring received the 1996 Humanitarian Award from the ISMS Alliance in April in recognition of her efforts to develop the first full-service library in a U.S. nursing home.



Don't forget to renew your license

Illinois physicians, beware. Your three-year medical and controlled substance licenses expire July 31. Physicians who do not renew their licenses by the deadline will be technically practicing without a license and could face disciplinary action by the Illinois State Medical Disciplinary Board. ISMIE policyholders who fail to renew will also lose their

medical malpractice coverage for the period of time they practice without a valid license.

The Illinois Department of Professional Regulation mailed renewal packets to all Illinois physicians in early June. Any physician who has not received renewal forms should contact IDPR at (217) 782-0458. ■

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IDPH honors resident for helping victim of auto accident

GOOD SAMARITAN: Physician receives Emergency Medical Services Award for her unhesitant action. BY DEBORAH PREISER

[CHICAGO] Making split-second decisions isn't hard for Patricia Griffith, MD, an engineer turned physician. Her instinctive quick action last summer at the site of an automobile crash probably saved a little boy's life – an act that recently made this resident in orthopedic surgery at Loyola University Medical Center in Maywood the first doctor to receive an Emergency Medical Services Award from the Illinois Department of Public Health.

"It is comforting to know there are people who will, often without regard for their own safety, come to the aid of someone in need," said IDPH Director John Lumpkin, MD, during the May 23 award ceremony at the State of Illinois Building in Chicago. Dr. Griffith was among the 21 individuals – mostly paramedics and firefighters – who were honored.

On June 24, 1995, Dr. Griffith was driving home on I-290 after a day with friends in the northern suburbs when she noticed a smashed and overturned car on the side of the expressway. Other motorists had stopped and begun pulling the accident victims from the car. "There was no question in my mind about whether to keep on going by," she said in an interview after the ceremony. "Not stopping was not an option for me."

Grabbing her stethoscope, she ran to Anthony and Tina Vogt, who had been pulled from the wreck, and found them in relatively good condition. "Just find my child!" screamed Tina Vogt. Moments later, an off-duty Schaumburg police officer, Thomas Tanner, located the 4-year-old under the Vogts' vehicle.

The police officer mobilized about 15 strangers who had stopped to help, and they lifted the car to pull young Matthew Vogt from beneath it. Dr. Griffith quickly discovered Matthew had suffered massive skull and facial fractures. "I remember putting my hand where his skull should be and feeling only softness," she said. "I knew right away he had a high chance of having a surgical spine injury and shouldn't be moved. Luckily, his blood pressure and breathing were stable, but I knew that could change. With the serious head injuries this child had, there could be massive brain swelling that could close off oxygen passages."

With the police officer's assistance, Dr. Griffith protected the child's cervical spine by immobilizing his head until paramedics arrived from Elk Grove Vil-

lage. After putting a cervical collar on Matthew and transferring him to a backboard, the paramedics loaded him into a Lifestar helicopter, which took him to Loyola University Medical Center's Level I trauma center in Maywood.

For the next 10 days, Dr. Griffith

visited Matthew in his hospital room every day. "By the time he went home, he was coloring pictures and playing in the playroom," she said. "Kids often do better than adults with these kind of injuries."

Illinois State Trooper Malcolm Mitani was also at the accident scene. About a year ago, he nominated Dr. Griffith for the lifesaving award, an annual honor given by the State Police Commission of



Dr. Griffith

Andrew Corrigan Halpern

Deputy Directors to recognize exemplary public service. In a memo to his sergeant, he said Dr. Griffith's presence and dedication to public safety prevented the accident from becoming fatal. Mitani wrote that Dr. Griffith conducted a head-to-toe evaluation of the boy after he was pulled from beneath the car, actions she undertook "without any reservation or second thought." Without her, "the child would have died on the scene," the memo said.

Dr. Griffith was also named "Cubs Hero of the Month" and given a special award by Cubs manager Jim Riggleman. (Continued on page 13)

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Angioedema and cough have been reported in patients receiving ACE inhibitors.

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Study shows doctors accepting more financial risk

RESEARCH: Plans delegate control over practice guidelines, referrals as doctors assume additional financial risk through capitation. BY KATHLEEN FURORE

[NEW YORK] An increasing number of IPAs and network model HMOs are accepting the risk for the cost of care they administer, according to a study released in early 1996 by the New York-based Commonwealth Fund. The study analyzed six managed care plans in Boston, Los Angeles and Philadelphia from April to July 1992.

“In the three markets studied, IPA and network plans are evolving away from financial contracts that initially retained discounted fee-for-service payment of physicians to arrangements that shift risk for the costs of care to the physician or physician group level,” reported the executive summary of the study. “In all three markets, plans are

moving toward delegating control of practice guidelines, referrals and subcontracts where they shift financial risk for a full range of medical services,” the summary said.

What that means is that plans are contracting with large physician groups and letting the physicians develop the guidelines they and their partners must

follow, said Cathy Schoen, co-author of the study. “Physicians are taking on what used to be the plans’ functions. In Los Angeles, for example, quite a few large doctor groups are taking over more direct control by taking on more risk [through capitation].”

The study also noted that Los Angeles area doctors are even accepting the full financial risk for specialty and hospital care as well as for the services they deliver directly.

In addition, the most successful plans have a provider-friendly and physician-focused philosophy; decentralized medical management; stable management, with a reputation for excellence; and a primary focus on developing an IPA or network HMO business, according to the study. In turn, those plans tend to develop long-term relationships with provider groups, which results in less turnover in the network and better continuity of care for plan patients, Schoen said.

THE FINDINGS SUPPORT the recommendations of managed care consultants like John Ray, president of the Clearwater Group Ltd., a California-based consulting firm. Ray has been instrumental in helping ISMS develop the Illinois Medical Physician Services Organization. “Profit is the reward for risk, and without taking risk, [physicians] have no claim over profit or control of decision-making,” Ray said. His comments echoed the study’s findings about the characteristics shared by successful groups: “They have to have physicians who are committed to a common enterprise. The common thread is that the organization is physician-driven, has good leadership and members’ commitment and loyalty. They have to have good management people in place who are supportive of physician-driven managed care and understand the business functions needed to make it work for doctors.”

The Illinois Medical PSO will offer consultation, development and information management services that will help physicians form the kind of successful, physician-driven managed care organizations studied by the Commonwealth Fund. The ISMS House of Delegates adopted a resolution affirming the implementation of the PSO at the Society’s Annual Meeting in April. ■

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Use In Pregnancy
When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Lotensin should be discontinued as soon as possible. See **WARNINGS, Fetal/Neonatal Morbidity and Mortality.**

INDICATIONS AND USAGE Lotensin is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics. In using Lotensin, consideration should be given to the fact that another angiotensin-converting enzyme inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen-vascular disease. Available data are insufficient to show that Lotensin does not have a similar risk (see **WARNINGS**).

Black patients receiving ACE-inhibitor monotherapy have been reported to have a higher incidence of angioedema compared to nonblacks. It should also be noted that in controlled clinical trials ACE inhibitors have an effect on blood pressure that is less in black patients than in nonblacks. **CONTRAINDICATIONS** Lotensin is contraindicated in patients who are hypersensitive to this product or to any other ACE inhibitor. **WARNINGS**

Anaphylactoid and Possibly Related Reactions
Presumably because angiotensin-converting enzyme inhibitors affect the metabolism of eicosanoids and polypeptides, including endogenous bradykinin, patients receiving ACE inhibitors (including Lotensin) may be subject to a variety of adverse reactions, some of them serious. **Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with angiotensin-converting enzyme inhibitors. In U.S. clinical trials, symptoms consistent with angioedema were seen in none of the subjects who received placebo and in about 0.5% of the subjects who received Lotensin. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with Lotensin should be discontinued and appropriate therapy instituted immediately. **Where there is involvement of the tongue, glottis, or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine injection 1:1000 (0.3 mL to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).**

Anaphylactoid Reactions During Desensitization: Two patients undergoing desensitizing treatment with hymenoptera venom while receiving ACE inhibitors sustained life-threatening anaphylactoid reactions. In the same patients, these reactions were avoided when ACE inhibitors were temporarily withheld, but they reappeared upon inadvertent rechallenge.

Anaphylactoid Reactions During Membrane Exposure: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes and treated concomitantly with an ACE inhibitor. Anaphylactoid reactions have also been reported in patients undergoing low-density lipoprotein apheresis with dextran sulfate absorption (a procedure dependent upon devices not approved in the United States).

Hypotension Lotensin can cause symptomatic hypotension. Like other ACE inhibitors, benazepril has been only rarely associated with hypotension in uncomplicated hypertensive patients. Symptomatic hypotension is most likely to occur in patients who have been volume- and/or salt-depleted as a result of prolonged diuretic therapy, dietary salt restriction, dialysis, diarrhea, or vomiting. Volume- and/or salt-depletion should be corrected before initiating therapy with Lotensin.

In patients with congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, Lotensin therapy should be started under close medical supervision; they should be followed closely for the first 2 weeks of treatment and whenever the dose of benazepril or diuretic is increased.

If hypotension occurs, the patient should be placed in a supine position, and, if necessary, treated with intravenous infusion of physiological saline. Lotensin treatment usually can be continued following restoration of blood pressure and volume.

Neutropenia/Agranulocytosis Another angiotensin-converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients, but more frequently in patients with renal impairment, especially if they also have a collagen-vascular disease such as systemic lupus erythematosus or scleroderma. Available data from clinical trials of benazepril are insufficient to show that benazepril does not cause agranulocytosis at similar rates. Monitoring of white blood cell counts should be considered in patients with collagen-vascular disease, especially if the disease is associated with impaired renal function.

Fetal/Neonatal Morbidity and Mortality ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible. The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of benazepril as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, benazepril should be discontinued unless it is considered life-saving for the mother. Contraction stress testing (CST), a nonstress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means

of reversing hypotension and/or substituting for disordered renal function. Benazepril, which crosses the placenta, can theoretically be removed from the neonatal circulation by these means; there are occasional reports of benefit from these maneuvers with another ACE inhibitor, but experience is limited.

No teratogenic effects of Lotensin were seen in studies of pregnant rats, mice, and rabbits. On a mg/m² basis, the doses used in these studies were 60 times (in rats), 9 times (in mice), and more than 0.8 times (in rabbits) the maximum recommended human dose (assuming a 50-kg woman). On a mg/kg basis these multiples are 300 times (in rats), 90 times (in mice) and more than 3 times (in rabbits) the maximum recommended human dose. **Hepatic Failure** Rarely, ACE inhibitors have been associated with a syndrome that starts with cholestatic jaundice and progresses to fulminant hepatic necrosis and (sometimes) death. The mechanism of this syndrome is not understood. Patients receiving ACE inhibitors who develop jaundice or marked elevations of hepatic enzymes should discontinue the ACE inhibitor and receive appropriate medical follow-up.

PRECAUTIONS
General
Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin-converting enzyme inhibitors, including Lotensin, may be associated with oliguria and/or progressive azotemia and (rarely) with acute renal failure and/or death. In a small study of hypertensive patients with renal artery stenosis in a solitary kidney or bilateral renal artery stenosis, treatment with Lotensin was associated with increases in blood urea nitrogen and serum creatinine; these increases were reversible upon discontinuation of Lotensin or diuretic therapy, or both. When such patients are treated with ACE inhibitors, renal function should be monitored during the first few weeks of therapy. Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea nitrogen and serum creatinine, usually minor and transient, especially when Lotensin has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction of Lotensin and/or discontinuation of the diuretic may be required. **Evaluation of the hypertensive patient should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).**

Hyperkalemia: In clinical trials, hyperkalemia (serum potassium at least 0.5 mEq/L greater than the upper limit of normal) occurred in approximately 1% of hypertensive patients receiving Lotensin. In most cases, these were isolated values which resolved despite continued therapy. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with Lotensin (see **Drug Interactions**). **Cough:** Presumably due to the inhibition of the degradation of endogenous bradykinin, persistent nonproductive cough has been reported with all ACE inhibitors, always resolving after discontinuation of therapy. ACE inhibitor-induced cough should be considered in the differential diagnosis of cough. **Impaired Liver Function:** In patients with hepatic dysfunction due to cirrhosis, levels of benazeprilat are essentially unaltered (see **WARNINGS, Hepatic Failure**).

Surgery/Anesthesia: In patients undergoing surgery or during anesthesia with agents that produce hypotension, benazepril will block the angiotensin II formation that could otherwise occur secondary to compensatory renin release. Hypotension that occurs as a result of this mechanism can be corrected by volume expansion.

Information for Patients
Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

Angioedema: Angioedema, including laryngeal edema, can occur at any time with treatment with ACE inhibitors. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, eyes, lips, or tongue, or difficulty in breathing) and to take no more drug until they have consulted with the prescribing physician.

Symptomatic Hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first days of therapy, and it should be reported to the prescribing physician. Patients should be told that if syncope occurs, Lotensin should be discontinued until the prescribing physician has been consulted. All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure, with the same consequences of lightheadedness and possible syncope. **Hyperkalemia:** Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting the prescribing physician. **Neutropenia:** Patients should be told to promptly report any indication of infection (e.g., sore throat, fever), which could be a sign of neutropenia.

Drug Interactions
Diuretics: Patients on diuretics, especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with Lotensin. The possibility of hypotensive effects with Lotensin can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with Lotensin. If this is not possible, the starting dose should be reduced (see **DOSAGE AND ADMINISTRATION**).

Potassium Supplements and Potassium-Sparing Diuretics: Lotensin can attenuate potassium loss caused by thiazide diuretics. Potassium-sparing diuretics (spironolactone, amiloride, triamterene, and others) or potassium supplements can increase the risk of hyperkalemia. Therefore, if concomitant use of such agents is indicated, they should be given with caution, and the patient's serum potassium should be monitored frequently.

Oral Anticoagulants: Interaction studies with warfarin and acenocoumarol failed to identify any clinically important effects on the serum concentrations or clinical effects of these anticoagulants.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving ACE inhibitors during therapy with lithium. These drugs should be coadministered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, the risk of lithium toxicity may be increased.

Other: No clinically important pharmacokinetic interactions occurred when Lotensin was administered concomitantly with hydrochlorothiazide, chlorthalidone, furosemide, digoxin, propranolol, atenolol, naproxen, or cimetidine.

Lotensin has been used concomitantly with beta-adrenergic-blocking agents, calcium-channel-blocking agents, diuretics, digoxin, and hydralazine, without evidence of clinically important adverse interactions. Benazepril, like other ACE inhibitors, has had less than additive effects with beta-adrenergic blockers, presumably because both drugs lower blood pressure by inhibiting parts of the renin-angiotensin system.

Carcinogenesis, Mutagenesis, Impairment of Fertility No evidence of carcinogenicity was found when benazepril was administered to rats and

mice for up to two years at doses of up to 150 mg/kg/day. When compared on the basis of body weights, this dose is 110 times the maximum recommended human dose. When compared on the basis of body surface areas, this dose is 18 and 9 times (rats and mice, respectively) the maximum recommended human dose (calculations assume a patient weight of 60 kg). No mutagenic activity was detected in the Ames test in bacteria (with or without metabolic activation), in an in vitro test for forward mutations in cultured mammalian cells, or in a nucleus anomaly test. In doses of 50-500 mg/kg/day (6-60 times the maximum recommended human dose based on mg/m² comparison and 37-375 times the maximum recommended human dose based on a mg/kg comparison), Lotensin had no adverse effect on the reproductive performance of male and female rats.

Pregnancy Categories C (first trimester) and D (second and third trimesters) See **WARNINGS, Fetal/Neonatal Morbidity and Mortality.**
Nursing Mothers Minimal amounts of unchanged benazepril and of benazeprilat are excreted into the breast milk of lactating women treated with benazepril. A newborn child ingesting entirely breast milk would receive less than 0.1% of the mg/kg maternal dose of benazepril and benazeprilat.

Geriatric Use Of the total number of patients who received benazepril in U.S. clinical studies of Lotensin, 18% were 65 or older while 2% were 75 or older. No overall differences in effectiveness or safety were observed between these patients and younger patients, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Pediatric Use Safety and effectiveness in pediatric patients have not been established.

ADVERSE REACTIONS Lotensin has been evaluated for safety in over 6000 patients with hypertension; over 700 of these patients were treated for at least one year. The overall incidence of reported adverse events was comparable in Lotensin and placebo patients. The reported side effects were generally mild and transient, and there was no relation between side effects and age, duration of therapy, or total dosage within the range of 2 to 80 mg. Discontinuation of therapy because of a side effect was required in approximately 5% of U.S. patients treated with Lotensin and in 3% of patients treated with placebo. The most common reasons for discontinuation were headache (0.6%) and cough (0.5%) (see **PRECAUTIONS, Cough**). The side effects considered possibly or probably related to study drug that occurred in U.S. placebo-controlled trials in more than 1% of patients treated with Lotensin are shown below.

PATIENTS IN U.S. PLACEBO-CONTROLLED STUDIES				
	LOTENSIN (N=964)		PLACEBO (N=496)	
	N	%	N	%
Headache	60	6.2	21	4.2
Dizziness	35	3.6	12	2.4
Fatigue	23	2.4	11	2.2
Somnolence	15	1.6	2	0.4
Postural Dizziness	14	1.5	1	0.2
Nausea	13	1.3	5	1.0
Cough	12	1.2	5	1.0

Other adverse experiences reported in controlled clinical trials (in less than 1% of benazepril patients), and rarer events seen in postmarketing experience, include the following (in some, a causal relationship to drug use is uncertain): **Cardiovascular:** Symptomatic hypotension was seen in 0.3% of patients, postural hypotension in 0.4%, and syncope in 0.1%; these reactions led to discontinuation of therapy in 4 patients who had received benazepril monotherapy and in 9 patients who had received benazepril with hydrochlorothiazide (see **PRECAUTIONS AND WARNINGS**). Other reports included angina pectoris, palpitations, and peripheral edema.

Renal: Of hypertensive patients with no apparent preexisting renal disease, about 2% have sustained increases in serum creatinine to at least 150% of their baseline values while receiving Lotensin, but most of these increases have disappeared despite continuing treatment. A much smaller fraction of these patients (less than 0.1%) developed simultaneous (usually transient) increases in blood urea nitrogen and serum creatinine.

Fetal/Neonatal Morbidity and Mortality: See **WARNINGS, Fetal/Neonatal Morbidity and Mortality.** **Angioedema:** Angioedema has been reported in patients receiving ACE inhibitors. During clinical trials in hypertensive patients with benazepril, 0.5% of patients experienced edema of the lips or face without other manifestations of angioedema. Angioedema associated with laryngeal edema and/or shock may be fatal. If angioedema of the face, extremities, lips, tongue, or glottis and/or larynx occurs, treatment with Lotensin should be discontinued and appropriate therapy instituted immediately (see **WARNINGS**). **Dermatologic:** Stevens-Johnson syndrome, apparent hypersensitivity reactions (manifested by dermatitis, pruritus, or rash), photosensitivity, and flushing. There have been rare reports of pemphigus in patients receiving ACE inhibitors. **Gastrointestinal:** Pancreatitis, constipation, gastritis, vomiting, and melena. **Hematologic:** Thrombocytopenia. There have been rare reports of hemolytic anemia in patients receiving ACE inhibitors.

Neurologic and Psychiatric: Anxiety, decreased libido, hypertension, insomnia, nervousness, and paresthesia. **Other:** Arthralgia, arthritis, asthenia, asthma, bronchitis, dyspnea, impotence, infection, myalgia, sinusitis, sweating, and urinary tract infection.

Clinical Laboratory Test Findings

Creatinine and Blood Urea Nitrogen: Of hypertensive patients with no apparent preexisting renal disease, about 2% have sustained increases in serum creatinine to at least 150% of their baseline values while receiving Lotensin, but most of these increases have disappeared despite continuing treatment. A much smaller fraction of these patients (less than 0.1%) developed simultaneous (usually transient) increases in blood urea nitrogen and serum creatinine. None of these increases required discontinuation of treatment. Increases in these laboratory values are more likely to occur in patients with renal insufficiency or those pretreated with a diuretic and, based on experience with other ACE inhibitors, would be expected to be especially likely in patients with renal artery stenosis (see **PRECAUTIONS, General**).

Potassium: Since benazepril decreases aldosterone secretion, elevation of serum potassium can occur. Potassium supplements and potassium-sparing diuretics should be given with caution, and the patient's serum potassium should be monitored frequently (see **PRECAUTIONS**). **Hemoglobin:** Decreases in hemoglobin (a low value and a decrease of 5 g/dL) were rare, occurring in only 1 of 2014 patients receiving Lotensin alone and in 1 of 1357 patients receiving Lotensin plus a diuretic. No U.S. patients discontinued treatment because of decreases in hemoglobin. **Other (causal relationships unknown):** Clinically important changes in standard laboratory tests were rarely associated with Lotensin administration. Elevations of uric acid, blood glucose, serum bilirubin, and liver enzymes (see **WARNINGS**) have been reported, as have scattered incidents of hyponatremia, electrocardiographic changes, leukopenia, eosinophilia, and proteinuria. In U.S. trials, less than 0.5% of patients discontinued treatment because of laboratory abnormalities.

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Amendment allows doctors to form limited liability companies

BENEFITS: Practice structure offers liability protection, tax advantages and management flexibility. BY KATHLEEN FURORE

[SPRINGFIELD] More options for practice structures have opened for Illinois physicians. They can now practice medicine through limited liability companies, thanks to legislation that amended Illinois' Medical Practice Act and the Limited Liability Company Act. LLCs, which have been described as a hybrid between for-profit corporations and partnerships, can give doctors the best of both worlds: They provide the liability protection typically offered by a corporation, and, if they satisfy IRS standards, they also offer the tax benefits of a partnership.

Before the amendment became effective Jan. 1, doctors were prohibited from practicing medicine through such entities, according to Anne Murphy, a health care attorney at Vedder, Price, Kaufman & Kammholz in Chicago and a partici-

where" in the use of LLCs for those kinds of entities. They allow for either centralized or decentralized management and offer "other flexibilities in governance and oversight features as well. If you have 20 investors – they're called members in an LLC – you can have all

20 members vote or you can set up a centralized board of managers similar to a corporation's board of directors."

"I think the real advantage of an LLC is the ease and efficiency of management," Clousson said. "If you have a small group, everyone could be a member of the management committee. If it is a large group, you could form a board of managers. It's still an internal governing body. But I think [setting up a board of managers] requires a little less structure than putting a board of directors in a bylaw" as is required in a corporation. Clousson's firm recommends that clients consider LLCs when deciding how to

structure their practices.

The statute that allows Illinois doctors to practice through LLCs, however, limits practice structures. To form a medical practice as an LLC, it says, all members, managers and directors must be licensed to practice medicine. But there is some flexibility in that provision. "You have to be careful in defining the practice of medicine," Murphy said. "Under appropriate circumstances, you can conclude that a given MSO activity, for example, might not be, strictly speaking, the practice of medicine. So there would be more flexibility in combining physician and non-physician members in those situations." ■

*The real advantage
of an LLC is the
ease and efficiency
of management.*

pant in ISMS' Lawyer Referral Network. The Medical Practice Act identifies the types of structures under which physicians can practice medicine, and previously, LLCs were not an option, she said. The Limited Liability Company Act, too, prohibited the practice of medicine through LLCs, Murphy added.

With few exceptions, physicians were limited to forming corporations that offered liability protection or partnerships that provided tax advantages. Both had downsides. Corporations have what Murphy called "the double-taxation problem" – the corporation's income and the shareholders' dividends are taxed. And partnerships are also subject to joint and several liability, Murphy explained.

"LLCs are relatively new legal entities," she said. "[But] I'm seeing them used quite a bit in the health care arena."

"We are seeing more use of LLCs by physicians, as you would expect because of the amendment," said Jerry Clousson, principal of Chicago's PSN Management Group and a participant in ISMS' Consultant Referral Service. "I think they are a little more manageable type of structure than a regular corporation, but they still provide the kinds of protections and tax consequences doctors look for."

Although LLCs are not limited to a managed care environment, they are especially attractive to managed care networks and provider-sponsored management service organizations because of their liability and tax benefits, Murphy said. They also offer organizational and operational flexibility. LLCs, in fact, came into existence as legal entities "around the time provider organizations accelerated the development of provider-sponsored managed care organizations," Murphy noted. She said she has seen "tremendous activity in Illinois and else-



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REPORT for Illinois Physicians

MEDICARE

TRUNCATED ICD-9-CM CODES ON ASSIGNED CLAIMS FOR PHYSICIAN SERVICES DENIED AND XX000 DISCONTINUED EFFECTIVE JULY 1, 1996

Since July 1, 1996, Medicare Part B has been returning assigned claims for physician services as unprocessable, when they are submitted with truncated diagnosis codes. Truncated diagnosis codes are ICD-9-CM codes submitted without an appropriate fourth or fifth level digit. Medicare has also been delaying the processing of unassigned claims until this additional information is received. Also, the use of fictitious diagnosis code XX000 has been discontinued.

Physicians should use the most current (1996) edition of the International Classification of Diseases, 9th Revision, Clinical Modification, Fifth Edition (ICD-9-CM), when billing claims. Diagnosis codes must be submitted at the highest level of specificity.

The ICD-9-CM lists codes with three, four or five digits, depending on level of diagnostic specificity. Three-digit codes may be subdivided by using a fourth or fifth digit. The three, four or five-digit code representing the most detailed diagnosis possible must be submitted. For example:

- ICD-9-CM code 204, *Lymphoid leukemia*, is a base code that has fourth and fifth digit classifications: 204.0, *Acute lymphoid leukemia*; 204.00, *...without mention of remission*; and 204.01, *...in remission*, the latter codes representing higher levels of specificity. If only 204 or 204.0 is submitted, the claim will be denied as unprocessable (assigned claims) or the additional information will be requested (unassigned claims), because a higher level of specificity can be coded.

Examples of the most frequently truncated diagnosis codes are:

250 - Diabetes mellitus	This code requires five digits. The fourth digit must be 0 through 9; the fifth digit must be 0 through 3.
715 - Osteoarthritis and allied disorders	This code requires five digits. The fourth digit must be 0, 1, 2, 3, 8 or 9; the fifth digit must be 0 through 9.

Adding zero (0) to a three-digit code which has no fourth or fifth digit is incorrect.

Electronic vendors, clearinghouses and billing services need to update their software to accommodate these changes.

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EDITORIAL

A burning issue

By now, suntans should be as anachronistic as leisure suits. For quite a while, we've known about the danger of tanning, whether outdoors or in a salon. But the bronzed skin on display this summer could lead you to believe that people are still blissfully ignorant of the risk.

Perhaps one problem is the mixed message being sent. The June issue of Vogue magazine recounts the experience of a dermatologist who traveled to Miami to ask women sunbathing at a hotel why they were still tanning and whether they knew about the risk. The women gave various excuses for sunbathing ranging from "I went to a tanning salon before I came here, so it's OK" to "I may get hit by a car tomorrow anyway" to "My mother had a precancerous growth removed last year, but I think I look better with a tan, and it's a gamble I'm willing to take." They admitted, however, that they knew tanning is generally dangerous.

Ironically, despite the story's healthful "don't tan" message, the cover of that issue showed a fashion model whose suntan could have qualified her as a potential poster child for skin cancer. So, the tanning message seems similar to the smoking one: It's bad for you, but glamorous, attractive people do it anyway.

Clearly, more of our patients need to understand that the risk stemming from unprotected sun exposure applies to them and that they need regular skin

exams. Skin cancer is now the most common form of cancer in the United States with about 1 million new cases diagnosed each year, according to the American Academy of Dermatology. By the end of 1996, there will be about 38,300 new cases of malignant melanoma – a 12 percent increase from 1995 – and 7,300 deaths attributed to malignant melanoma, according to AAD predictions. Of those deaths, 4,600 are expected to be men, and 2,700 women. Despite the fact that women have a lower death rate, they are especially at risk: Melanoma is the most frequent cancer in women between ages 25 and 29, and is the second most frequent in women between 30 and 34, after breast cancer.

Children need protection, too. We know that malignant melanoma has been linked to patients' past sunburns and sun exposure at young ages. But many kids are still playing outside without sunscreen and sun-protective clothing.

To help fight melanoma, the AAD is sponsoring an education campaign and free skin cancer screening examinations for the public. As of early May, 832,000 screenings had been conducted. AAD members even provided free screenings to their fellow physicians during the AMA's Annual Meeting last month.

Sunburn is the most preventable risk factor for skin cancer, including malignant melanoma, according to the AAD. Practicing prevention will keep us all from getting burned.

PRESIDENT'S LETTER

On-line – s_olson@nwu.edu

Sandra F. Olson, MD



I'm finding lots of cultural, practical and broadening sources that a person can get at the tap of a key.

How do you like my latest address? I feel as if I have finally caught up to the computer generation – a little late, perhaps, but I'm getting there. And yes, I now have my own personal, portable computer. "What's the big deal?" you ask. Lots of doctors are computer literate – especially the younger ones. In fact, your immediate past President Dr. Ray Hoffmann is a very sophisticated, computer-ite. Why is this such a step for me? After all, my husband and children are very electronically savvy. My son is a computer programmer in New York.

I have a little experience – reading EEGs on a computer. Manipulating the display of data to improve the accuracy of interpretation became fun and stimulating. I began to personally experience power over the information I was gaining. A whole world opens up when you realize what is at your fingertips. Oh, I knew it was there before, I had just felt helpless dealing with it, and I was able to get done what I thought I needed to do in the old-fashioned way.

But I think there are several reasons why many of us "older folks" have been slow to seize this technology personally. I have analyzed my own reluctance and have come up with several reasons.

First, I don't type well – I'm just not comfortable with the keyboard. Second, I'm not much of a gadgeteer for personal use. I confess to being quite leery of losing material in a computer. Horror stories of losing receipts, records, are frightening to me. And thirdly, in my office, we have managed with a simple accounting system and appointment book for years. My secretary does like electronic billing now that she has become comfortable with it, but she shares my phobias and distrust of too many gadgets even though she is an outstanding typist. As for literature searches, I have the library right next door to me, plus I have kept my major journals for years, so it's easy to get articles any time I need them.

But I know I've been fooling myself. Serving on the American

Academy of Neurology subcommittee on computers and information systems has helped open my eyes. So, a few years ago, I said to my husband, Ron, "Let's order one – the time is ripe." Now it was his turn to delay. "Wait, something new is just about to come out," he said. This conversation repeated itself every three to six months until two months ago when Ron walked into the living room and announced he had ordered it.

So now I'm learning the functions and applications of this tool. A few of the new, exciting uses in medicine are interactive CME, literature searches that are simple to get, drug information, lab results, X-rays, etc., which you are all familiar with. But I'm finding lots of cultural, practical and broadening sources that a person can get at the tap of a key "by surfing the Net" – and I must mention the games and other bits of whimsy like the one you see at the end of this letter.

I'm sure that most of you are well-versed and familiar with these applications, so I won't dwell on them. But why am I chronicling my saga through microchip land? Because I think I represent a large group of physicians who are still relatively unsophisticated in the capabilities of computers other than day-by-day familiar uses, such as bank transactions, financial records, ordering, etc. It is estimated that five to 10 years from now, it will be literally impossible to practice medicine without intimate familiarity with these machines. Patient records, images, medication schedules will all be sorted electronically. Paper will still be around but will only be a sketch of the patient – the full picture will be on the screen. This will be the opposite of what our present status is. The electronic age is here, and we must embrace it. But I hasten to add that computers will still never walk in, sit down next to a patient, hold a hand, wipe a tear or pat an arm. We human docs are still in charge. ☺

LETTERS

Just the facts — on violence prevention

I read the editorial and the feature article on arresting violence (May 24 issue). I am dismayed by the political posturing that appears to be motivated by research from the Centers for Disease Control and Prevention and the New England Journal of Medicine article, which has been discredited, on the dangers of gun ownership.

I am especially distressed that ISMS policy is supporting the right of communities to enact local ordinances that will interfere with the right to keep and bear arms. I would like to remind you of the Second Amendment to the Constitution.

I do not believe that I am some wacky Freeman, but I do believe that law-abiding citizens have the right to protect themselves and their families from criminals.

It is extremely naive to assume that banning guns will eliminate violence. States like Florida, which have liberal gun laws and allow private citizens to carry concealed guns, have demonstrated reduced violent crime.

— Alan Froehling, MD
Mt. Vernon

Billboards, classroom and public transport posters, anti-violence public announcements and gun control will not cut it. Our society refuses to make the necessary changes to halt the continued decline of our culture.

Maybe we could reverse the violence in our society in a generation if we did the following things: cease subsidizing illegitimacy; institute foster homes or orphanages to raise children rescued from child abuse, multiple children of unwed mothers and irresponsible, dysfunctional parents; design a solution to

eliminate violence from our entertainment media; and restore the teaching of morality in our public schools.

If we fail to give our children a moral compass, the despair that Dr. May decries will continue.

— Leo Green, MD
Alton

Medicine shouldn't be a convenience store

Thanks and congratulations to Dr. Sandra Olson for her cogent piece "Death Wish" (June 7 issue). It is reassuring to see this medical leader holding the line on active euthanasia. She duly notes the sad testimony that up to 75 percent of Americans support physician-assisted suicide. The real question is, How long has this been the case? Many years ago, anthropologist Margaret Mead noted, "Society always is attempting to make the physician into a killer — to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. It is the duty of society to protect the physicians from such a request."

We should remember that we are a profession and not a convenience store. I am sure that 75 percent of the population would also favor our giving free services or medications to anyone who wanted them or misrepresenting facts to their insurance company, but that doesn't make those actions right or possible. If "majority rules" on this kind of issue, we may democratically develop ersatz "values" or "morality," but we won't have anything truly ethical. There is a difference.

— William Schuler, MD
Mendota

Illinois Medicine reserves the right to edit all letters to the editor.

GUEST EDITORIAL

This judicial ruling resists logic

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Americans have long had the sense that their liability system is out of control, often capriciously awarding large amounts of money to people who deserve small amounts — or none at all. Among those sharing that unease are a majority of the U.S. Supreme Court, which recently overturned as unconstitutionally excessive a \$4 million punitive damage award against German automaker BMW for selling as new a car whose paint had been retouched in several places.

That sense has fueled the movement for tort reform, which has spread from the state legislatures to Congress as elected lawmakers try to restore common sense and proportionality to our civil courts. The Illinois General Assembly took a stab at reform in 1995, passing a measure that included a limit of \$500,000 on noneconomic damages in personal-injury lawsuits.

But that modest measure has now run up against a Cook County Circuit judge, who found it to be in violation of both the federal and the state constitutions. In what is just the first step in litigation that will ultimately end up with the Illinois Supreme Court, Judge Kenneth Gillis invalidated the cap, viewing it as "irrational" and a partial repeal of the state right to a jury trial.

Gillis thinks it is the height of unfairness for people with economic losses to be able to recover to the full extent of the injury, while people with noneconomic losses are limited. This disparity, he insists, has no rational basis.

But of course it does. Economic losses can be quantified with rough precision — in lost wages, medical bills, transportation costs and the like. Noneconomic losses like pain and suffering or loss of companionship are entirely subjective and thus are an invitation for a jury confronted by a large corporation and a

sympathetic plaintiff to let its generosity run riot. It is perfectly rational to regard them as therefore vulnerable to abuse.

Gillis thinks the cap discriminates against people who are, say, retired and thus lose no income from an accident. But it is not discrimination to say that where there is no loss, there is no obligation to compensate.

The argument that this change violates the state right to "a jury trial as heretofore enjoyed" is also unconvincing. A plaintiff is still entitled to submit his claim to a jury, which will evaluate and dispose of it. The judge's reading suggests that any change in jury practice is forbidden. But preserving a right is not the same as freezing a custom for all eternity.

The General Assembly made a sober and judicious attempt to deal with a real problem. The irrationality in this case lies elsewhere.



Brian Warling

CITED FOR HER exceptional work and personal sacrifice in helping physician policyholders, Karen Sturm recently received ISMS' Employee Recognition Award. She is a senior professional liability analyst in the Springfield office.

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45	\$1,305	\$1,035	\$1,535	\$1,185
50	\$2,015	\$1,425	\$2,405	\$1,665
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Dr. Goetcheus says that raising her children in a health recovery facility for the homeless is one of the greatest gifts she has given them.

Her gifts to her patients are even greater. Caring for Washington's homeless for almost a decade, she despaired at seeing simple medical problems grow severe when patients lacked a clean, quiet place where they could heal. Her answer was to found Christ House, a live-in respite care facility for the homeless — and home to her family.

Today, this center is part of Washington's Health Care for the Homeless Project. As medical director of both, Dr. Goetcheus is serving in an even greater capacity, reviving health and hope in those she serves.

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ISMIE Update

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PAGE 2

Illinois AIDS Confidentiality Act raises liability issues

Physicians should always get written informed consent before ordering testing for HIV. BY WENDY ANDERSON

Fran Brown, MD, receives a subpoena requesting "any and all" medical records related to a patient named Donovan, who is alleging bodily injury in a lawsuit. In reviewing her files, Dr. Brown sees that Donovan signed a standard form authorizing the release of medical information, so she complies with the subpoena. Included in the medical records she sends are the results of an HIV test. Later, Dr. Brown is shocked when Donovan slaps her with a lawsuit alleging she violated the Illinois AIDS Confidentiality Act by releasing his HIV test results.

In the example, Dr. Brown failed to realize two things, according to attorney Brian Rocca of Chicago's Fedota & Rocca. First, a patient's signing a standard form for the release of medical records doesn't authorize the release of HIV-related information. Even a patient's blanket "waiver of privilege" consent form – a device some lawyers have been using to obtain records in discovery – doesn't allow a health care provider to reveal HIV information.

Second, a subpoena cannot compel the release of HIV-related information, Rocca said. "Subpoenas are not effective as relates to certain confidential information covered by statute – HIV, drug abuse and treatment, and psychiatric information. Discovery rules in Illinois govern what records can be disclosed, and [lawyers have] to make a special showing to get HIV and other records."

Penalties for violating any of the AIDS act's provisions range from payment of liquidated damages to criminal misdemeanor charges and malpractice suits, according to Rocca.

To avoid legal woes, doctors should familiarize themselves with the AIDS act, which, with limited exceptions, requires physicians to get written informed consent even before ordering an HIV test, Rocca

said. A standard consent form doesn't suffice, he explained, unless it includes HIV-specific information. The Illinois Department of Public Health has developed a sample form that doctors can adapt for their practice. To request it, physicians may write to IDPH, AIDS Activity Section, 525 W. Jefferson St., Springfield, IL 62761.

Specifically, the consent form asks for the patient's permission to perform a blood test to detect antibodies to HIV or any other identified causative agent of AIDS. The form explains that a positive finding will be reported to IDPH (without the patient's name), that counseling as required under the act will be provided to anyone with a positive result and that the patient's written consent and test result will be specially coded for anonymity if the patient so desires. It also states that the patient may withdraw from the testing at any point prior to the completion of lab tests.

Rocca provides his physician clients with a release form that includes HIV specifics. To standard language authorizing a health care provider to permit records to be examined and photocopied, the release adds "including all history sheets, diagnoses, blood tests including HIV tests and records regarding HIV/AIDS status." Wording about a patient's waiver of any privilege has been expanded to read "whether grounded in the common law or statute including but not limited to the Illinois AIDS Confidentiality Act."

A CASE DESCRIBED by Rocca illustrates the importance of written informed consent. A patient entered the emergency department with acute appendicitis after experiencing three days of diarrhea and was given a provisional diagnosis of infectious diarrhea, for which hospital policy required his isolation. The patient also revealed that his sex-

ual partner had died from AIDS. The doctor ordered an HIV test, and the patient verbally agreed. The patient later sued, claiming among other things that he had been tested for HIV without his written informed consent.

In addition to mandating specific, written informed consent, the act imposes other requirements, Rocca said. For example, the fact that an HIV test even occurred cannot be revealed without the patient's specific consent. And even with written informed consent, a patient's HIV status can be revealed only to those individuals whom the act defines as legally authorized health care providers. Patients have filed lawsuits, for example, if their HIV status was clearly stamped on a medical chart easily read by a variety of hospital personnel, Rocca said.

To minimize the risk that a patient's HIV and AIDS records might be illegally revealed,

physicians should somehow segregate that information within the chart, said a risk management specialist. But that segregation should be done so as not to call attention to the records, said Rocca. "If you segregate the chart – put it in a private place – then everybody knows it's an HIV-positive patient because it's one of those segregated charts," he said. And that would call unwanted attention to the chart.

IF A PHYSICIAN has only one HIV-positive patient in a several-physician practice with a patient base of 10,000, HIV-related information could be placed in a sealed envelope marked "confidential," and the envelope could be placed on the patient's chart, Rocca said. But the physician shouldn't stop there. "Do you put [an identical but empty envelope] on every one of your 10,000 patients' charts? If you want to protect yourself, you bet," Rocca explained. And while support staff can type up the envelopes, the provider, not the support staff, must put any HIV-related information in the envelope. Then when a subpoena comes along, physicians can easily send only the records unprotected by the AIDS act or other statutes.

Legal issues related to HIV aren't limited to the gay community. Rocca said questions arise in family and internist practices, and in pediatrics, where there are third-party issues – for example, whether to release HIV information to, or get consent for testing from, a third party as defined under the act. Rocca described a typical scenario: "A parent calls and says, '[My] 13-year-old daughter is sexually active and hanging around with guys who might be doing drugs, and I'd like to have her tested for STDs and AIDS. Would you do that the next time she comes into the office?'" That situation places the physician "in a very tough spot," he said, because it raises a potential lawsuit for invasion of privacy. Doctors should remember, "the parent is not the patient," he advised.

The same holds true if parents discover their minor child had an HIV test and they want to know the result, or if a minor simply asks a doctor to perform an HIV test. In the latter situation, the onus is on the doctor to determine that the minor is competent and understands what is being requested, Rocca said. "I always advise erring on the side of treating information as confidential." ■

ISMIE contracts with broker Kamensky Group

EXPANSION: New agency specializes in professional liability.

BY KATHLEEN FUREORE

[CHICAGO] The Arlington Heights-based Kamensky Group Inc. has become the sixth brokerage firm authorized to represent ISMIE and sell ISMIE products, according to Harold Jensen, MD, chairman of the ISMIE Board of Governors. "Contracting with brokers has enabled us to expand the range of insurance products and services we can offer our policyholders," he said. "This new contract with the Kamensky Group further enhances physicians' access to a variety of markets and gives ISMIE even broader geographic coverage than it has had before." That is especially important, he said, in a

managed care environment in which group practice administrators and other nonphysicians are making insurance-buying decisions.

Head of the company is Todd Kamensky, an insurance agent for 12 years who deals only with medical professional liability products. He writes some \$4 million in annualized professional liability business. "All our agency does is specialize in professional liability [products], so we always are up on new things that are happening," he said. "And we do a pretty large book of business in the nonstandard market. It works well because we can still help physicians who have had

claim frequency or claim history problems or those who do very high-risk procedures."

Because he once worked as a paralegal doing claims reviews for physicians, Kamensky said he has special insight into physicians' insurance needs. "I went through the medical malpractice crisis with the doctors. ISMIE is one of the few companies that has been there for physicians through all the ups and downs."

The company joins Aon, Classic Insurance Services Ltd., Diederich Insurance, Medical Arts Insurance Affiliates Ltd. and Medical Group Insurance Services on the roster of ISMIE-approved brokers. ■

HOSPICE OFFERS COMPASS

The palliative approach can be seamlessly

BY KARE

At the recent AMA Annual Meeting, physicians, the media and the world were riveted by the issue of physician-assisted suicide. AMA delegates overwhelmingly reaffirmed the organization's opposition to the practice. In discussing the vote, Chairman of the AMA Board of Trustees Nancy Dickey, MD, said, "Physicians must be armed with the knowledge and the know-how to compassionately control pain and encourage and preserve patient autonomy." Compassionate pain control and patient autonomy are provided through one option that has often been overlooked — hospice care. But that could change as hospice loses its status as the "stepsister" of medicine and evolves into a model for managed care, according to medical professionals who are active in hospices.

"I see hospice as the medical model for the future, especially given the move toward managed care. This is managed care for terminal patients," said Mary Cooper, RN, patient care coordinator for the hospice program at Decatur Memorial Hospital.

"Hospices are helping physicians and hospital groups develop guidelines for hospice care," said Martha Twaddle, MD, medical director of the Evanston-based Hospice of the North Shore. "Hospice is only now becoming incorporated into integrated delivery systems, with hospitals actually contracting with hospices."

Hospice can be a strong adjunct to traditional medical care because it offers such benefits as a comprehensive focus on the patient's support network, a reliance on patient directives and the potential for savings over hospital-based care.

Despite their benefits and potential, however, hospices may not be widely accepted, in part because of their lack of consistency, said James Wade, MD, medical director of the Decatur Memorial Hospital hospice program. "What one hospice program might consider to be within its philosophy may be different in another. We rarely provide blood transfusions in our hospice program, for example, while other programs may routinely provide them."

In addition, not all hospice programs are Medicare-certified, nor do all boast a strong physician base, Dr. Twaddle said.

In Illinois, hospice programs are licensed by the Illinois Department of Public Health, according to Rosemary Crowley, executive director of the Chicago-based Illinois State Hospice Organization, whose members account for 85 of the state's 115 to 118 hospice programs. (Exact figures are unavailable because of recent mergers.)

Hospice eligibility requirements are fairly standard, though, Crowley said, and are primarily set by the U.S. Health Care Financing Administration. Generally a patient's life expectancy must be six months or less, and the patient and family must elect nonaggressive symptom control and pain management rather than aggressive treatments. Medicare patients are eligible for hospice benefits; states also have the option to extend hospice benefits to their Medicaid recipients, which Illinois does.

Requirements of private and third-party insurers vary, but "many insurers are amenable to hospice care, because hospice can almost assure that hospitalization costs will be negligible," Crowley said. Although the cost savings of hospice care over tra-

ditional medicine are not as high as originally believed, they can still be significant, especially in the final months of life, according to a recent article in JAMA.

For patients to choose hospice, their primary care physician and the hospice medical director must sign a certificate verifying that the option is appropriate. But that should be just one step in hospice involvement for primary care physicians.

Ideally, primary care doctors should mention hospice as an option early on, said Dr. Twaddle, perhaps even at the time of diagnosis. Although hospice care is unlikely if traditional medical treatment is recommended, a preliminary discussion about hospice allows physicians to broach the subject later if treatment isn't working. "Then we can say to patients, 'Remember we talked about hospice a few months ago?' and help them focus on symptom control and comfort care," she explained.

"If the referral comes at the appropriate time, hospice can be of great benefit to the patient and family," said David Moore, DO, HIV program director at Illinois Masonic Medical Center



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in Chicago. But physicians who recommend hospice only after every available treatment possibility has been exhausted often wind up with patients and family members who are exhausted, too, and who are unable to address quality of life issues, Dr. Twaddle said.

Dr. Twaddle added that she has seen patients enter a hospice program and die within hours. "What are we, the undertaker? The potential for hospice is so much greater than that, but doctors too often see hospice as a black-and-white issue, rather than as part of a transition process for the patient."

THE PALLIATIVE APPROACH used in hospice care often runs counter to what physicians are taught in medical school, Crowley said. "Doctors need to understand that even if they're not treating a disease aggressively, they are still treating the person."

The decision about when to recommend hospice has been complicated by AIDS, a disease that often follows an unpredictable course and affects a young patient population. Physi-

cians treating AIDS patients tend to fall naturally into one of two camps, Dr. Moore said. "Some doctors, the minute they learn a patient has AIDS, want to recommend hospice. Others want to pull out all the stops and fight this disease until the very end."

The middle ground is for physicians to continue interacting with their patients who have entered hospice programs. "The idea of hospice is not to supplant the primary care doctor," Dr. Twaddle said. "Rather, the hospice physician's role is one of consultant." He or she serves as a resource for the primary care doctor, helping with symptom management and pain control, she explained. "A good patient-physician relationship is a painkiller in and of itself."

At the Decatur Memorial Hospital hospice, for example, the primary care doctor helps Dr. Wade and his colleagues review patients' medications, plan a course of treatment and determine which treatments can be safely eliminated while maintaining the quality of life. "We usually stop weekly laboratory work, for example, because needle sticks are not without pain," Cooper explained.

Dr. Twaddle said she sometimes has difficulty "letting go" of a patient emotionally. "Even when I refer my own patients to hospice care, I find myself saying, 'This woman has been in my practice for 10 years, she's a wonderful woman, and I need to be a part of this to make sure that she's going to be getting the best care possible.' This can be an intense time for the doctor as well as the patient."

"But doctors don't need to shoulder all the care," Dr. Twaddle continued. "They don't need to be the social worker or chaplain. They're part of a team."

IN ADDITION TO social workers and chaplains, the team may include nurses, psychologists and counselors. The patient and family are also key team members, said Anne Redmond, former volunteer coordinator for the hospice program at Illinois Masonic and currently a counselor with BE-HIV, an Evanston-based HIV/AIDS support program. Redmond, whose father died in a hospice program two years ago, recalled her frustration when her father was denied additional pain medication. She said family members were not asked what they wanted or how they thought her father was handling pain.

Physicians may become more inclined to involve family members in decision-making as they learn more about hospice and its role in patient care, said Charles von Gunten, MD, director of palliative care services at Northwestern University Medical School in Chicago. "Palliative medicine is a specialty, just like cardiology or nephrology," he said. "For too long hospice has been considered an alternative. It's more accurate to think of it as the completion of good medical care, and it should be seamlessly integrated into the total plan of care for a patient."

In today's highly volatile and politicized medical environment, hospice care can restore an element of dignity to physicians as well as patients and their families, Dr. Twaddle said. "Many physicians are discouraged with medicine, cynical about what they're doing and tired of fighting with HMOs. But hospice is probably one of the most enjoyable areas of medicine right now. It's not fraught with technology, and it's not overrun with politics and business. It's about the patient-physician relationship and providing care. Hospice returns your soul to medicine." ■

Federal debate on confidentiality to continue

COMPUTERIZED RECORDS: Some health care professionals say Bennett bill doesn't go far enough. BY MINDY S. KOLOF

[WASHINGTON] Technological advances have been responsible for quantum leaps in U.S. medical care, but they often stir up ethical, moral and legal concerns. The latest case in point is the increasing computerization of medical records and their retention in large databases, which could compromise patient confidentiality and lead to denials of health insurance coverage and employer

discrimination. To address those potential problems, the U.S. Senate is considering the Medical Records Confidentiality Act of 1995, introduced by Sen. Robert Bennett (R-Utah). According to Washington sources, the bill probably won't progress this session but is likely to be reintroduced later.

The bill would establish uniform, comprehensive federal rules governing

the use and disclosure of patient-identifiable health information; delineate the responsibilities of those who collect, use and maintain health information; define patients' rights regarding their health information; and create mechanisms to protect patients' rights, including criminal and civil penalties for those who misuse such information.

Most health care professionals agree on the need for such legislation but say the Bennett bill doesn't go far enough. "We do not support the bill in its present form because we have concerns over the issue of disclosure," said Ross Rubin, vice president of legislative affairs for the AMA. "There is a requirement that the information remain confidential, but the bill contains a laundry list of exceptions. We feel that access to medical records should be limited to the physicians treating the patient or on a need-to-know basis."

The bill's provisions are based on current procedures for disclosing and correcting consumer credit information, but the two fields are not the same, according to the AMA. "We have concerns about the patient review and correction procedures," Rubin said. "Subsequent holders of medical information, such as information data banks, should not be allowed to change medical information or conclusions."

St. Louis health care lawyer T. Evan Schaeffer expressed similar misgivings: "Although the bill allows patients to obtain their records and attempt to correct errors, the exceptions to these rights swallow the rule," he wrote in a recent

Chicago Tribune guest editorial. The bill "sanctions the creation of computerized data banks of medical information without patient consent, provides patients no opportunity to decline participation in data banks and actually makes insider access to medical information easier than it was before," he wrote.

The American Health Information Management Association, a professional organization of more than 35,000 health information management specialists, disagreed. "The Medical Records Confidentiality Act of 1995 will ensure strong and consistent privacy safeguards whether the health information is in paper or electronic form," said Linda Kloss, AHIMA's executive director.

An important component of the bill is its granting patients the right to access their own health information, she added. Only 28 states now allow patients to do so, according to the AHIMA.

Yet the erosion of previously private physician-patient communication is the greatest danger the bill presents, according to Rubin. "The physician-patient relationship is based first on trust, and the confidentiality of communications is the cornerstone of good medical care. For physicians to provide the best and most appropriate medical care, patients must feel they can disclose personal facts and information they would not want others to know. Without this, patients may not provide the information necessary [for doctors] to properly diagnose and treat [them]."

Jennifer Katze, MD, of the Maryland

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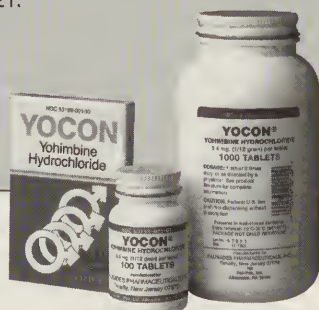
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Psychiatric Society, opposes the bill because of its potential influence on medical care itself. "There would be grave social consequences, because if people don't trust that their information will be kept confidential, it will deter them from seeking treatment," she said in a Chicago Tribune story.

Katze is working to create a medical data bank in Maryland that would use encrypted codes instead of patient names. "All the information about someone's body and mind would go into a big, fat computer database," she said. "If a guy plunked down \$100 on my desk and told me he needed help because he was afraid he might molest a child, I would be required to enter a computer-coded file in the system with his age, ZIP code and diagnosis of pedophilia."

Genetic testing presents another area of concern to health care professionals. "What does it mean right now to do testing on a 20-year-old who has the breast cancer gene?" asked George Hanson, MD, a pediatric geneticist at the University of Illinois at Chicago Medical Center. "What does that mean for her insurability?"

With each advance in genetic testing, the potential for misuse of test results increases. A recent USA Today article said that "most [insurance] discrimination today is based on information obtained

Widespread testing might mean widespread interest in the results by employers and insurers, which could lead to denials of coverage and employment discrimination.

from medical records." The article pointed out that DNA screening tests for conditions such as heart disease, Alzheimer's disease, breast cancer and diabetes will probably become commercially available within 10 years. Widespread testing might mean widespread interest in the results by employers and insurers, which could lead to denials of coverage and employment discrimination.

Patient privacy should be maintained, but patient information should be more widely accessible, said Norman Black, director of public affairs for Equifax, a large information management company for the health care, financial services and insurance industries. "There is a need for patient IDs to be stripped to discover important health care findings," he said. "But we'd lose tremendous benefits if we were not able to access this information."

ISMS supports the preservation of patient confidentiality in all circumstances. The Society's Code of Medical Ethics states, "A physician shall respect the rights of patients and shall safeguard patient confidences within the constraint of the law." In addition, House of Delegates policy says access to individual identifiable employee medical records by employers or government agencies, except as required by law, is contrary to traditional and legal medical practice and conflicts with the patient's best interest. ■

Resident honored

(Continued from page 3)

She said she was surprised by the amount of attention she got for doing what came naturally.

"Seeing a 4-year-old who was that seriously injured was an emotional experience for me," Dr. Griffith said. "I'm just grateful that I got the chance to help."

In situations like the one Dr. Griffith encountered, all physicians can feel free to help without fear of liability thanks to state law providing immunity to doctors who help at accident scenes.

Despite her enthusiasm for helping

people, medicine was not Dr. Griffith's initially chosen field. With a bachelor's degree in chemical and petroleum-refining engineering, she began her career as a product development engineer but she said she wanted more: "I liked the idea of pursuing a career that would combine a lot of people interaction with applied science." So, she returned to college to earn a bachelor of science degree in molecular, cellular and developmental biology from the University of Colorado before starting medical school. Her engineering aptitude and experience drew her to orthopedic surgery, a field with relatively few women.

"I see a lot of rewards in this field,"

said Dr. Griffith. "In the normal course of things, you see your patients improve a lot. Often they come to you in great pain — and within weeks or months you see great improvement."

Dr. Griffith said she hopes to complete a sports medicine fellowship after she completes her residency in June 1997. A former high school and college track star, she has worked as a basketball official for the Illinois High School Basketball Association and as team physician for Fenwick High School in Oak Park, Triton College in River Grove, Lewis University in Joliet and the NCAA Division II Cross-Country Championships. ■



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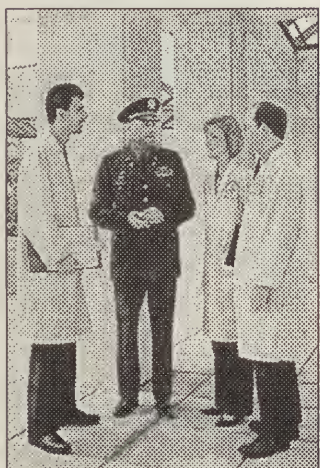
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If you are interested in more information or wish to submit a C.V. for consideration, please contact:

Julia A. Marcuzzo, PHR
Employment Coordinator
Covenant Medical Center
3421 W. 9th Street
Waterloo, IA 50702
Ph: 319-292-2330

Janice Yagla
Physician Placement Coordinator
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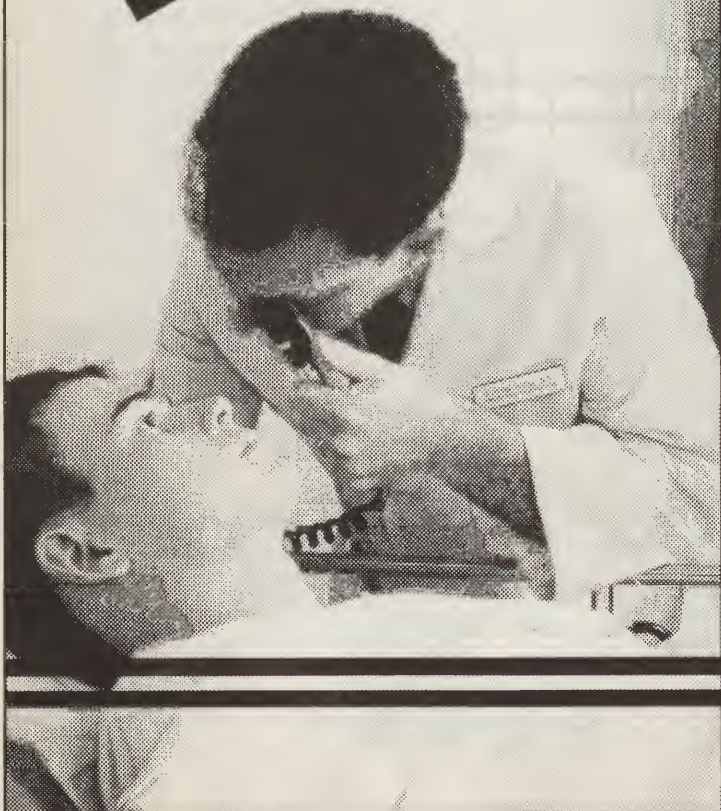
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ISMS kicks off meetings

(Continued from page 1)

"The PSO will provide a mechanism for doctors to maintain their clinical independence because it will be run by physicians for physicians," Dr. Fesco said. "It will help them control the pen with which they write orders for patients. It will help ensure they can provide adequate and complete patient care without being constrained by insurance companies, HMOs or other third-party payers that don't necessarily have patient care as their bottom line [objective]."

Other state medical societies – including those in Washington, California, Michigan and Pennsylvania – have sponsored and/or funded managed care initiatives, said John Ray, interim chief operating officer of the Illinois Medical PSO. "The fact that ISMS is doing the PSO is not unique. There's a good track record [for such ventures]." He added, however, that the Illinois Medical PSO will be unique in that it will be the only physician-owned, centralized information source in the state that physicians can turn to for the kind of help they need to succeed in a managed care marketplace.

SPECIFICALLY, THE NEW ORGANIZATION plans to offer a sophisticated management information system to help physicians track such important data as payments from managed care plans. That is especially important for doctors with many managed care contracts who may unknowingly receive less compensation than their contracts specify, Dr. Fesco said. "It should be a level playing field. But right now, physicians don't have the software or the information available [to track payments] because they are in contracts with hospitals or other third-party payers who control that information. The Illinois Medical PSO will make sure that kind of information is available to physicians."

Dr. Sprang said such services exceed what ISMS, as a member organization, could offer. "The consulting and information services are beyond ISMS' capabilities. The amount of information physicians need [in a managed care environment] is staggering. They need the number of patients in and out of plan, physician care models and outcomes data, what's billed and received."

The PSO will help physicians obtain such information as economically as possible. "If you're doing it for 10,000 doctors and hundreds of thousands of patients, it's much more cost-effective than any one doctor or group could do on their own," Dr. Sprang said.

Initially, the Illinois Medical PSO will help physicians with such activities as entering into managed care contracts that are most favorable to them. "Physicians spend so much of their time in continuing education courses and keeping up with the explosive growth of medical technology that they may not be interested in or prepared for negotiating contracts or investigating their relationships with HMOs and other third-party payers," Dr. Fesco explained. That's why the Illinois Medical PSO's services will put physicians in stronger negotiating positions than ever before and prepare them to operate successfully within the contracts they sign, he added.

Unlike some nonphysician-operated management services organizations, the

Illinois Medical PSO will tailor its services to the specific needs of each physician client. Consequently, it will help ensure that Illinois doctors have opportunities for clinical, professional and economic growth in the burgeoning managed care marketplace, Dr. Fesco said. "The PSO will help physicians manage managed care for the benefit of our patients."

ISMS "HAS A GOOD track record [in similar business ventures]," Dr. Fesco continued. In 1976, it launched the Illinois State Medical Inter-Insurance Exchange, which now writes more than half the

medical malpractice insurance in Illinois, he said. "ISMIE is a success because it is physician-driven and -controlled, with no third-party involvement."

"This is similar to when we created ISMIE as a separate, physician-driven, physician-directed, physician-friendly organization," Dr. Sprang added. "Other insurance companies have come and gone, but ISMIE has always been here for physicians. The PSO will be the same way. There are dozens of other management services organizations that are for-profit and here for the short haul. But the Illinois Medical PSO is here for the long haul for the best interest of physi-

cians and patients. It is here to provide tools for physicians so they can control health care.

"Change does present opportunity," Dr. Sprang continued. That opportunity lies in helping physicians find ways to control the future of medicine, he said. "Only doctors have the education, the experience and the expertise to practice medicine. We can't relinquish it to anyone else – it's not in the best interests of physicians or patients."

The statewide meetings will be conducted throughout the summer and fall and are open to all physicians. For more information, call (888) ISMS-PSO. ■

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IDPA informs

(Continued from page 1)

Most complaints stem from recipients' lack of understanding of managed care, according to Paulette Jordan, a health benefit representative at a Michigan Avenue IDPA office in Chicago. "I feel, from what I hear, that lack of education [about managed care] is the biggest problem. The basic complaint is that people are turned off by HMOs because they have to operate within the HMO's plan."

Jordan said she explains which physicians and hospitals are available through various HMOs. "I'll explain [managed care] from beginning to end. Some will remain [in the HMO]; others will disenroll." If a new enrollee doesn't want information about managed care, Jordan explains fee for service, she said.

The health benefit reps are also charged with identifying questionable marketing practices by some Illinois Medicaid HMOs. A common complaint, for example, is that marketers may tell recipients that they must enroll in a particular HMO to retain their Medicaid benefits, Jordan said. Such a complaint would be investigated, she said, with the rep asking the recipient to file a formal complaint.

In light of such complaints about marketing abuses, U.S. Rep. Richard Durbin (D-Ill.) held a community hearing in Chicago on July 1, which was attended by HCFA officials and will be covered in an upcoming issue. Joining Durbin in the effort to stem any marketing abuses are

other federal lawmakers from Illinois — Reps. Cardiss Collins, Luis Gutierrez, Jesse Jackson Jr. and Bobby Rush. According to Durbin, it's especially important to develop safeguards before MediPlan Plus is implemented and HMO enrollment increases. "The time to correct these problems is now, while only a relatively small percentage of Illinoisans are enrolled in the managed care program."

IDPA's efforts to eliminate dubious marketing practices are important from a patient care perspective, especially given that projected increase, said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. "If, because of misleading marketing, a patient signs up for a plan that is in an inaccessible location or that doesn't include the physician who has been providing care, that can disrupt continuity of care." And such disruptions ultimately cause patients to disenroll, which imposes extra costs and administrative burdens on the entire system, he added.

ISMS previously urged IDPA to make sure recipients receive adequate education before making any choice related to MediPlan Plus.

IN ADDITION TO CONTRACTING with health benefit reps, IDPA has taken other steps to educate recipients about its affiliated HMOs and the role of their marketers. The department sent a letter to all recipients in late June telling them that enrollment in HMOs is not mandatory and

that the health benefit reps can answer any questions about managed care. By the end of summer, some 250 Medicaid managed care workshops will have been conducted by community organizations such as the Woodlawn Organization and the Proviso-Leyden Council for Community Action Inc. in Maywood, Schott said. These are scheduled to be held at neighborhood block meetings, local school council meetings and churches throughout Chicago and suburban Cook County, he explained.

"We do not tolerate situations where clients are coerced or misled about the [managed care enrollment] process," Schott said. Although IDPA's contracts with HMOs allow door-to-door marketing, he stressed that the department always reviews reports of deceptive practices and refers cases it cannot settle to the state's office of inspector general for investigation.

Of the 38 cases the OIG has reviewed to date, it has substantiated 12 instances of abuse. "Those cases involved four HMO marketers, and the marketers were dismissed by the HMOs before IDPA even completed the investigation," Schott said. Any marketer found guilty of misleading or deceiving clients is banned from working with other HMOs in the IDPA system, he noted. IDPA is also in the process of freezing enrollment for managed care entities with patterns of violations, said Nellie Ryan, chief of IDPA's bureau of managed care.

A toll-free hot line, (800) 226-0768, has been set up so that enrollees and

physicians can inform IDPA of any alleged HMO marketing abuses. In addition, IDPA keeps a list of marketers in good standing, meets regularly with participating HMOs and approves all marketing materials and marketing plans so that it can monitor the marketing and enrollment process, Schott said.

Ryan said IDPA would have undertaken the education initiative regardless of MediPlan Plus, adding that patients can't really choose providers unless they're informed. ■



PRINCESS DIANA tours Chicago's Cook County Hospital trauma unit as part of a June visit to Chicago to raise funds for cancer research. With the princess is John Barrett, MD, chairman of the unit. Northwestern Memorial Hospital sponsored the royal stay.

AP/Wide World Photos

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(Continued from page 1)

ure out an effective response to managed care."

In most for-profit HMOs, said Dr. Turner, at least 20 percent of all insurance-premium money goes to the insurers' profit and administrative overhead. Physicians must work to reverse that trend, increasing the percentage of the premium spent on patient care. One way to do that is to create a physician-hospital partnership, which "has high value in the marketplace," Dr. Turner said. An integrated group of physicians with consistent incentives can align with a hospital to meet both groups' goals and share the risk, he said. The notion of creating an integrated not-for-profit health care network similar to Kaiser Permanente's HMOs is now being considered in many communities, he explained. Kaiser Permanente is known for its good patient care and for returning about 92 cents on the dollar to health care, he said.

*Hospital administrators
view the world as a
Christmas tree with them
at the top, while doctors
see the world in pre-
Copernican terms – as
flat, with everyone a peer
and no one able to tell
anyone else what to do.*

"When for-profits come into the community, their commitment isn't to the community," Dr. Turner explained. "They come in and take the profits out." Employers and employees are growing uneasy with what they perceive as "a lack of value for their money from large insurance-type HMOs," Ray said. Managed care organizations that are essentially providers of care rather than insurers have the longest successful track records because "they deliver high value for the money added over time," he said.

Ray said managed care began as a direct alliance between physicians and employers. The first managed care and capitation plan was developed in 1933 by Sidney Garfield, MD, a Los Angeles physician who established a group practice prepayment plan for workers on a construction project in the Southern California desert. Monthly dues payments of 5 cents per day were collected through payroll deductions. Dr. Garfield and contractor Henry J. Kaiser went on to form Kaiser Permanente, which today has more than 6.6 million members.

Although organized groups of physicians have demonstrated the ability to be successful in managed care, PHOs don't have an established track record, Ray said. Creating a PHO requires reconciling two dramatically different world views into a partnership that will work in the marketplace. "Hospital administrators view the world as a Christmas

tree with them at the top, while doctors see the world in pre-Copernican terms – as flat, with everyone a peer and no one able to tell anyone else what to do."

Ray suggested three tests of the viability of a PHO. First, does it have its own independent capital, or is it dependent on the hospital budget? Second, does the PHO have an independent, experienced CEO or a hospital manager on loan? And third, is the PHO free to negotiate hospital rates in the market?

To help the two groups work together, PHOs typically create a board of directors whose members equally represent both entities and

are elected by both, said attorney Joan Polacheck of McDermott, Will & Emery in Chicago. Each group contributes equal capital to result in equal ownership, and a majority of the members from each entity must approve all actions. The PHO handles managed care contracting for its members, Polacheck said.

The experts agreed that successful PHOs have some common traits: committed leaders who seek alliances, extensive capital and an "A" bond rating, an independent senior executive experienced in managed care and the freedom to negotiate hospital rates and decide how

the pool of surplus will be allocated.

To help physicians organize themselves to succeed in managed care, ISMS developed the Illinois Medical Physician Services Organization, which will provide consulting and network-development services; managed care operations services such as claims processing and enrollment, eligibility and benefits verification; and practice management assistance.

"Physicians are reawakening to their role as partners in delivering excellent care within a fixed budget," Ray said. "They are committing themselves to their common enterprise, investing in themselves and accepting financial risk." ■

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Lawsuit against Aetna dismissed

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Matt Ferguson

GOV. JIM EDGAR describes the importance of two pro-patient, ISMS-supported bills after he signed them on July 17. He said that in moving toward managed care, changes will need to be made, such as those provided by H.B. 2557 and S.B. 1246. See story, page 2.

HCFA approves waiver for MediPlan Plus

MEDICAID: State can proceed with plan to adopt a managed care approach to improve health care delivery and control costs. BY KATHLEEN FUREORE

[SPRINGFIELD] Gov. Jim Edgar announced July 12 that The U.S. Health Care Financing Administration had formally approved Illinois' Medicaid reform program, MediPlan Plus. "I am pleased that this plan is now approved," Edgar said. "The objectives of MediPlan Plus remain as sound today as when I first presented the proposal to the General Assembly in March 1994. MediPlan Plus aims to ensure Medicaid clients have access to the right medical services at the right time while using the cost-control strategies that have proved effective in the private sector."

MediPlan Plus was designed to improve health care delivery to the state's 1.1 million Medicaid recipients and to rein in costs by adopting a managed care approach for the system, according to the Illinois Department of Public Aid. The General Assembly approved the plan in July 1994. However, the state could not implement the program until HCFA approved a waiver that lets IDPA assign a primary care provider to recipients who do not select one, locks enrollees into their pro-

vider for one year and allows for the development of Managed Care Community Networks, which will contract directly with the program. Under current federal law, state programs can lock recipients into a capitated system for no more than six months, and the Medicaid patient base of a capitated entity's enrollment cannot exceed 75 percent.

Through the new plan, recipients throughout the state will be asked to choose either a fee-for-service primary care physician who will function as a gatekeeper, an HMO, an MCCN, a Federally Qualified Health Center or a rural health clinic. Patients will have three months from the time they're presented with their health care choices to make a selection. Those who fail to choose will be "defaulted" to a capitated managed care system, according to George Hovanec, IDPA's director of medical programs. IDPA expects that the earliest the first recipients could be enrolled would be fiscal year 1998, which begins July 1997. Consequently, the current voluntary system will continue (Continued on page 10)

Illinois Medical PSO Board announces stock offering

OPPORTUNITY: Illinois physicians can invest in their futures by helping to capitalize a doctor-owned and doctor-directed company. BY KATHLEEN FUREORE

[CHICAGO] Illinois physicians can now invest in the new Illinois Medical Physician Services Organization Inc., announced Edward Fesco, MD, chairman of the Illinois Medical PSO Board of Directors. The announcement came after the Illinois secretary of state on July 19 declared the registration of the stock offering to be effective. "This is an exciting new chance for physicians to invest in their future," Dr. Fesco said.

Successful capitalization is key to the implementation of the Illinois Medical PSO, a physician-driven company dedicated to providing physicians — whether in solo or group practice — with support and services in negotiation and contracting, practice development, managed care operations, administrative and financial planning, and

capital formation, Dr. Fesco explained. The independent, for-profit corporation will be owned by physician investors in the company's preferred stock and the Illinois State Medical Holding Co., a wholly owned subsidiary of ISMS, he noted. "The PSO will let doctors maintain their clinical independence because it will be run by physicians for physicians," Dr. Fesco added.

"Physicians interested in looking at the future and seeing what's going on would be almost shortsighted not to want [to invest in] such an entity," said M. LeRoy Sprang, MD, a member of the Illinois Medical PSO Board of Directors. "It's a question of who's going to be in charge of medicine — insurance companies, hospitals, MBAs or physicians."

To help guarantee that physicians will always lead the Illinois Medical PSO, only individuals who are either licensed to practice medicine in the state or have voluntarily surrendered their license to practice medicine are eligible to buy the stock, which is priced at \$1,000 per share. Investors must also be Illinois residents. The minimum investment is five shares of voting-participating preferred stock totaling \$5,000. Investors who make the minimum purchase can also buy up to 10 additional shares of nonvoting-participating preferred stock.

Stockholders who own voting preferred shares will elect four of the Illinois Medical PSO's 13 Board members, said ISMS General Counsel Saul Morse. The holding company, (Continued on page 13)

INSIDE

Illinois EMS for Children aims to meet kids' special needs



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Hearing focuses on HMO marketing practices aimed at Medicaid recipients

FORUM: Enrollees, providers, government officials discuss problems. BY DEBORAH DOWLEY PREISER

[CHICAGO] The Illinois Department of Public Aid is prepared to expand safeguards to ensure that Medicaid enrollees have real choices and that Medicaid HMOs abide by the rules, said IDPA's Director of Medical Programs George Hovanec at a forum on HMO marketing practices. The forum was held July 1 at the Dirksen Federal Office Building in Chicago at the request of U.S. Reps. Richard Durbin, Luis Gutierrez and Bobby Rush.

Hovanec was one of 13 panelists including Medicaid recipients, Chicago-area health pro-

viders and state and federal officials. Prior to the U.S. Health Care Financing Administration's July 12 approval of the waiver to implement MediPlan Plus, nearly 180,000 Medicaid recipients had enrolled in nine different HMOs, primarily in Cook County, Hovanec said. HMOs were able to solicit Medicaid enrollees directly.

Several of those enrollees described marketing practices and HMO problems that they or their family members experienced. Medicaid enrollee Tabitha Washington said her sister (Continued on page 15)

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Gov. Edgar signs pro-patient, ISMS-supported bills

MANAGED CARE: Measures will affect health care for women.

BY JANICE ROSENBERG

[CHICAGO] On July 17, Gov. Jim Edgar signed into law two pro-patient bills that will affect health care for women and that were supported by ISMS. H.B. 2557 requires insurers to pay for at least 48 hours of inpatient care for mothers and newborns following a vaginal delivery and 96 hours following a cesarean section. S.B. 1246 allows women enrolled in managed care plans to select a participating Ob/Gyn as their "principal health care provider" whom they can access without referral or prior approval.

In describing the importance of H.B. 2557, Edgar said, "Too often new mothers and babies are hurried out of hospitals to save costs for insurers. It is crucial in our system of fair play that we not allow the desire to save money to put a mother and newborn child at risk. This legislation will help assure that we have our priorities right."

One of the bill's sponsors, Rep. Kay Wojcik (R-Schaumburg), said, "I know those women who are now going to

have a baby will not have to face the crisis of leaving the hospital sooner than expected." She congratulated the governor and the state legislators responsible for advancing the bill.

Another sponsor, Sen. Robert Madigan (R-Lincoln), credited the measure's passage to legislative teamwork and called its progress through the General Assembly a classic example of the way government should work.

Edgar said that S.B. 1246, which allows women to designate Ob/Gyns as their principal health care providers, reflects the continuing need to refine managed care. "Managed care is pretty much a new concept that most people have recognized is the direction we need to move [toward], but that doesn't mean there isn't a need to modify it as we move. In no way does this mean managed care doesn't work. What this underscores is that we can take managed care and recognize as we move along with it that there are needs for some changes."

Bill sponsor Rep. Rosemary Mulligan (R-Des Plaines) said, "Managed care is supposed to save money, and it is also supposed to provide good care." She added that the lack of direct access to an Ob/Gyn meant that some women were not receiving optimal care, since that Ob/Gyn was often their sole medical contact.

ISMS President Sandra Olson, MD, spoke of the significance of the legislation in terms of patient care. "We see these bills as important steps in guaranteeing quality health care by the physicians of their choice to all the citizens of Illinois."

In signing the bills the governor did what was in the best interest of the women and newborns of Illinois, said Chairman of the ISMS Board of Trustees and Evanston Ob/Gyn M. LeRoy Sprang, MD. "We're not opposed to managed care, but the pendulum had swung too far. It's time to bring it back toward the middle and do what is in the best interest of our patients."

The new laws demonstrate that the basic right to high-quality medical care can be maintained under managed care plans, Dr. Olson said. "These laws involve women and children, but we want to see that everyone gets high quality health care from the physicians of their choice. That's why we're so enthused about the Managed Care Patient Rights Act. We now must focus on the rest of its provisions."



Dr. Sprang (from left), Edgar, Dr. Olson

The Managed Care Patient Rights Act is a comprehensive, bipartisan-supported measure that was introduced into the General Assembly last February. It would establish basic rights for Illinois patients who participate in managed care plans.

"While the Managed Care Patient Rights Act did not pass in the Illinois legislature's 1996 spring session, Illinois physicians are pleased to see two vital aspects of that bill enacted into law today," Dr. Olson said. "We are committed, on behalf of our patients, to pursuing passage of the act." The bill is currently under review and will be reintroduced, she said.

Campaign offers Ritalin information

ISMS Web site provides for information exchange on managed care and other issues

[CHICAGO] ISMS has created an Internet site on the World Wide Web to allow patients, physicians and legislators to exchange information about health care issues. The site, <http://www.isms.org>, currently gives patients updated information about managed care and asks them to describe their experiences with managed care plans.

"The Web site is an interactive tool that patients and members can use to learn more about the Managed Care Patient Rights Act," said ISMS President Sandra Olson, MD, citing the bill developed by ISMS and introduced into the Illinois General Assembly during the spring legislative session. The act, which will be reviewed and possibly revised prior to its reintroduction, provides comprehensive protections for patients enrolled in managed care plans. The managed care bills that progressed during the spring session focused on more narrow protections, such as those needed to avoid drive-through deliveries.

"People can also give us important feedback on their experiences, whether good or bad, with managed care," Dr. Olson added. "Not only can we give information to patients, but we can also learn about managed care through the patients' own experiences. Every day, in offices just like mine, doctors see patients who have experienced delays, frustrations and denials in getting the care they need from managed care plans."

"We encourage everyone who expects high-quality care from his or her managed care plan to visit our Web site," Dr. Olson continued. "In our fight for patient rights, we are using every available tool to increase public awareness, including cyberspace technology."

Specifically, the Web site asks viewers

if they or family members have had problems getting what they and their physician agreed they needed from their managed care plans. Patients who have experienced problems are encouraged to note them so that their state legislators can learn about them directly.

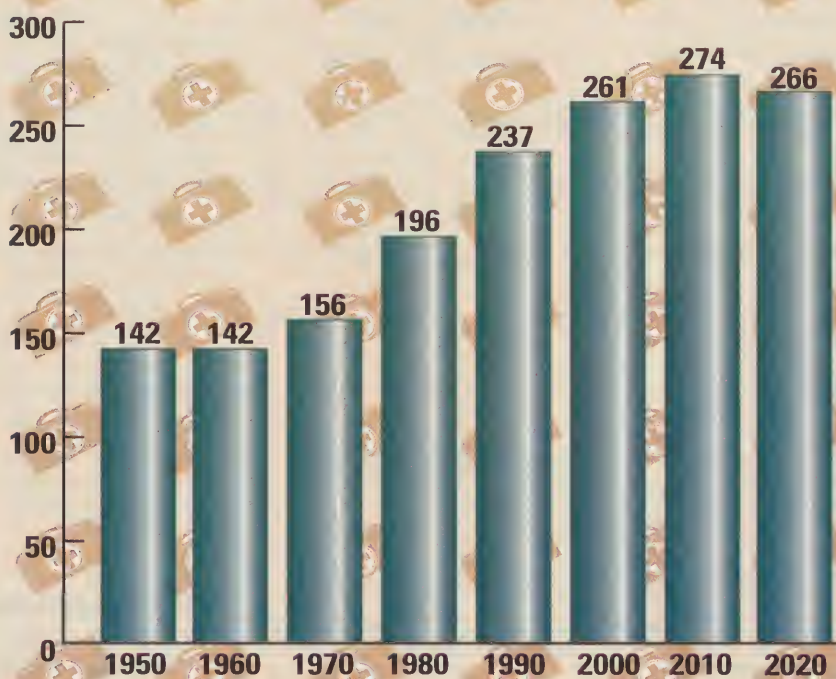
"Patients need to get their state legislators to support this act," Dr. Olson

said. "So far, it has gained more than 40 legislative co-sponsors."

"The end of the recent legislative session really marks the beginning of the next phase of our fight for patient rights," Dr. Olson said. "This year we introduced lawmakers to the issue of patient rights in managed care, and we even achieved protection for the rights of a limited group of patients: new mothers and their babies. Through the Web site and other communication channels, we can continue our progress on patient rights into the next General Assembly session."

Doctors in numbers

Number of physicians in the United States per 100,000 population from 1950 through 1990 and projected to 2020



Source: the National Academy of Sciences

[SUMMIT, N.J.] Ciba Pharmaceuticals recently launched a campaign to inform physicians, parents and patients about the proper use of Ritalin, which is used to treat Attention Deficit Hyperactivity Disorder. The company sent educational materials to some 110,000 doctors and to more than 100,000 pharmacies and medical institutions nationwide asking them to share the information with their ADHD patients and patients' parents or guardians. Increased misuse of Ritalin prompted the educational effort, according to information from Ciba.

Dubbed "The 3 Rs of Ritalin: Read, Respect, Responsibility," the campaign focuses on the need for ADHD patients and their caregivers to read about ADHD and its treatment, to respect themselves and Ritalin by properly using the drug and to take responsibility for their actions as well as the actions of others in helping to prevent potential problems, said Joyce Moscaritola, MD, Ciba's vice president of medical affairs.

"Only through a concerted, nationwide campaign of information and education, designed for the ultimate benefit of the patient, can we be confident that we are meeting our responsibility to better ensure the appropriate use of Ritalin," Dr. Moscaritola said.

The materials sent to physicians include a brochure to be distributed by pharmacists each time a Ritalin prescription is filled, a brochure designed for school nurses and a sheet that lists such information about Ritalin as its clinical pharmacology, contraindications, warnings and dosage. The materials will help physicians "become familiar with this campaign and see firsthand what your patients and their caregivers will be reading. Hopefully, through education we can eliminate the potential for misuse and abuse," Dr. Moscaritola wrote in her letter to physicians.

ADHD afflicts an estimated 3 percent to 5 percent of U.S. schoolchildren.

Illinois EMS for Children aims to meet kids' special needs

PEDIATRICS: Program enhances access to and quality of emergency care. BY KATHLEEN FUREORE

[MAYWOOD] A federal program designed to help states improve pediatric emergency medical services is helping Illinois address the special needs of the state's critically ill and injured children. Through the Illinois Emergency Medical Services for Children initiative, appropriate medical resources are made available at whatever point children enter the EMS system. The state program was launched in 1994 when the Illinois Department of Public Health and Loyola University Medical Center received a grant from the federal EMSC program, according to Evelyn Lyons, an Illinois EMSC research assistant and a nurse at Loyola.

The national EMSC effort dates back to 1984 when the U.S. Congress approved a grant program to enhance access to and quality of emergency care for children nationwide. Today, Illinois is one of more than 40 states with EMSC programs funded with federal grants.

EMS systems were originally developed in the late 1960s to treat adult cardiac and trauma patients. The systems were derived from military medical care, which showed that survival could be substantially improved with appropriate triage, timely transport and prehospital treatment. Consequently, EMS programs rarely addressed children's needs, and emergency care education programs did not traditionally include specialized pediatric training, according to information from the Illinois EMSC.

"The system certainly was developed to take care of adults, and kids were sort of treated as an aside," said David I. Rosenberg, MD, medical director of pediatric critical care medicine and transport for the Rockford Health System, Children's Medical Center. "But children are not little adults. They have unique needs." For example, he explained, they require weight-specific doses of medications and smaller instruments than those used for adults.

Symptoms of potentially life-threatening conditions also manifest themselves differently in children than in adults, Dr. Rosenberg said. "The clinical signs of dehydration in adults are lethargy and an increased heart rate. But in children, the symptoms are more subtle. And if someone is not experienced, they won't pick up on them."

"Children have a higher incidence of morbidity and mortality [than adults] nationwide in connection with the emer-

gency care system. So there is clearly a need for enhancement," said Linda Gutfeld, Illinois EMSC program manager.

State and national statistics underscore the importance of a child-focused EMS program. Every year, more than 10,000 children in Illinois alone are injured seri-

ously enough to require hospitalization at a trauma center, and 4 percent of those patients die from their injuries.

But one of every 2.2 to 3.6 of those fatalities could be prevented if better emergency treatment and injury prevention activities were available, according to Illinois EMSC estimates. Nationally, 10.4 million children visit the emergency department; 360,000 require hospitalization; and at least 50,000 are permanently disabled annually as a result of injuries. Leading causes of injury and death are motor vehicle accidents, falls, firearm injuries, fires, suffocation/hanging/choking, and drowning, Gutfeld said.

To achieve its goal, the Illinois EMSC program will focus its resources in five areas over the next two years: training of health care professionals, public education, enhancement of the pediatric emergency care system, pediatric data collection and children with special health care needs such as those who have undergone tracheostomies. Those areas were selected based on a statewide needs assessment study conducted when the program began in 1994, Gutfeld said.

An overwhelming number of physicians, nurses, paramedics and health care facilities surveyed, for example, said they

(Continued on page 10)



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REPORT for Illinois Physicians

ALLAN M. KORN, M.D.

**VICE PRESIDENT AND CORPORATE MEDICAL DIRECTOR
MEDICAL DEPARTMENT**

Allan M. Korn, M.D. joins the staff of Blue Cross Blue Shield of Illinois as Vice President, and Corporate Medical Director to further the organization's relations with physicians, physician groups and health care providers throughout the State. The relationships between payor, provider and patient are frequently misunderstood. Through collaboration, candid communication, and clinically meaningful data, BCBSI believes that more effective clinical and economic outcomes can and should be achieved by all participants in the health care delivery process.

Dr. Korn, a board certified internist, practiced in Evansville, Indiana for ten years, caring primarily for cancer patients. In 1986, he joined Health care COMPARE Corporation of Downers Grove, Illinois. During his five years with that company, first as Medical Director, then as Vice President of Medical Affairs, Dr. Korn participated in the development of utilization review, large case management, chiropractic review, mental health/substance abuse review, and Worker's Compensation cost management programs. He helped develop a claims analysis process focusing on the medical necessity of care, completed pharmacy review programs for major clients, and also served as the Medical Director for an expanding national PPO.

As a Principal at William M. Mercer, Incorporated, Dr. Korn developed techniques to measure quality of care based on outcomes assessment, and the application of this data to selective contracting. With others, he developed techniques for implementing Continuous Quality Improvement programs in hospitals and provider organizations. He also assumed responsibility for working with clients to:

- Evaluate, implement and monitor HMOs and PPOs;
- Evaluate, implement and monitor vendors of managed care services;
- Improve the efficiency of inpatient and outpatient care delivery; and
- Extend the processes of managed care into the Workers' Compensation environment, with experience in heavy industrial, mining and white collar settings.

While at Premier Health Alliance, as Senior Vice President of Medical Affairs, Dr. Korn developed programs which:

- Provided meaningful educational opportunities for practicing physicians struggling with managed care issues;
- Maintained a technology assessment program making it available to practicing clinicians;
- Developed a clinical data system, severity and risk adjusted, to help integrated delivery systems improve outcomes; and
- Lead a physician service initiative providing an open-ended "answer-line" to clinicians, linking each physician in a Premier affiliated institution to the collective experience or wisdom of the Alliance

Dr. Korn is a graduate of Tufts University School of Medicine, and completed post-graduate training at Northwestern University and the Mayo Clinic.

Dr. Korn co-authored a chapter on outpatient utilization review in "Ambulatory Care Utilization Review, Ambulatory Care Management and Practice," Aspen Publishers, Inc., and co-authored "Managed Workers' Compensation: A Human Resource Approach to Reducing Costs," John Wiley and Sons, New York, February 1994.

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EDITORIAL

One for the road

Illinoisans seem to be taking the tip to have one – or more – for the road a bit too literally. The National Highway Traffic Safety Administration recently released statistics on the number of alcohol-related traffic deaths in our state. Although that figure was lower in 1995 than 10 years ago, the number of such deaths actually increased last year for the first time since 1989. Of the 1,586 total highway deaths in Illinois last year, 681 involved alcohol – a 3.8 percent increase over 1994, the NHTSA reported. Those numbers reflect a national trend: Of 41,798 traffic deaths in 1995, 41.4 percent involved alcohol, up from 40.7 percent in 1994.

Based on the increase in Illinois, Secretary of State George Ryan is renewing his call for state legislators to lower Illinois' legal blood alcohol limit for drivers from .10 percent to .08 percent. ISMS' House of Delegates policy supports the .08 percent limit. In a story in the Daily Herald, Ryan cited an NHTSA estimate that the lower limit would reduce deaths by 10 percent. He also referred to studies showing that even drivers with an .08 percent blood alcohol level are three times more likely to be involved in a car crash than drivers who have had no alcohol and that they're 11 times more likely to be involved in a fatal single-vehicle crash.

Related to drunken driving are the problems of binge drinking and excessive alcohol consumption by young people – behaviors the AMA plans to combat

through a long-term program begun in May. AMA Chairman of the Board of Trustees Nancy Dickey, MD, said, "When 40 percent of young Americans admit to excessive drinking and 20 percent to binge drinking – and when 20 percent of those who drink admit to driving drunk – we must take dramatic steps to safeguard the lives and health of our young people." The program will develop up to 12 state and community coalitions, which will be funded by grants and will create projects to reduce young people's alcohol use. In addition, up to eight universities will receive grants to work at changing entrenched alcohol consumption on campus. Education programs aimed at those who drive and abuse alcohol are supported by ISMS' HOD policy.

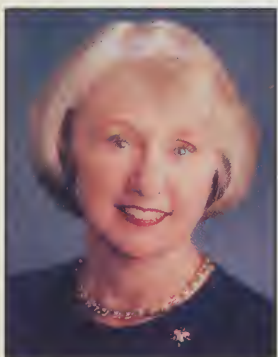
College students who drink and drive are the focus of an organization called the National Group Rides and Designated Drivers. The group's goal is to create and support a national network of collegiate "safe ride" programs to help save lives in college communities. If you think that focus is narrow, consider that binge-drinking college students are six times as likely as their more moderate-drinking peers to drive after drinking alcohol and twice as likely to accept a ride from an intoxicated driver, according to a Harvard University study.

Let's hope that the statistics for 1996 will show that we're back on the road to safe and sober driving.

PRESIDENT'S LETTER

Meeting notes

Sandra F. Olson, MD



These were lively, open and candid forums with thoughtful comments on various sides of many issues.

The AMA just concluded its Annual Meeting here in Chicago – a meeting that may prove to be pivotal in the AMA's future. I thought I might share with you my impressions of the various deliberations and activities that went on during the official – and unofficial – sessions.

The opening session on Sunday started with a flourish of national pride as a student color guard solemnly presented the colors. We all sang the national anthem and bowed our heads in prayer. Next came awards to physicians and members of the public for service to the profession and patients. Afterward came various speeches including the address of President Lonnie Bristow, MD, and our own P. John Seward, MD, the new executive vice president.

After these patriotic and inspiring hours, the real work began as the reference committees convened. Serving on them were many of our delegates including Drs. John Schneider, Pat Merwick, Ed Fesco, Clair Callan and Michael Suk. These were lively, open and candid forums with thoughtful comments on various sides of many issues. This year the committees did an outstanding job distilling hours of diverse testimony into concise but thorough reports that truly reflected the opinions voiced. Their hard work helped smooth final deliberations on the floor of the House.

There were 108 reports and 214 resolutions that made up the official business of the meetings. Illinois introduced 12 resolutions as directed by ISMS' House of Delegates. Of those, nine were adopted; two were accepted as a reaffirmation of existing policy; and one was adopted as amended, so we scored a batting average of 1,000!

Physician-assisted suicide was the topic that attracted the most national attention from the media. There were several resolutions on this topic, including one introduced personally by Dr. Ulrich Danckers, an Illinois delegate, which asked the AMA to take a neutral stand on the issue until public discussion provided a national con-

sensus and direction. Testimony was passionate but overwhelmingly in favor of reaffirming the present policy against the practice. There were no less than eight TV cameras in the room when the issue was debated and a vote was taken on the House floor. Another hot topic was a resolution calling for mandatory HIV testing of all pregnant women and babies. After a long discussion, this resolution squeaked through by a 185-181 vote.

The delegates again considered the issue of mandatory point-of-service options in all health care plans. Present AMA policy supports optional POS-type features. This issue had been debated extensively at the 1995 interim meeting, and the House reaffirmed its present position.

Two more public health issues that captured extensive attention were domestic violence and the regulation of tattoo artists and facilities. The delegates addressed the violence issue by calling on the association to evaluate a national standard for the prosecution of such cases and to work with advocacy groups to help ensure the personal safety of victims. The resolution on tattoo parlors was nicknamed "the Rodman resolution." It calls on states to regulate these facilities and to protect the public from infection and allergic reactions.

Lastly, an important decision about the future of the AMA was made by the delegates when they voted to restructure the composition of the House of Delegates and increase representation from specialty societies. This would reapportion the delegates in general but would increase the size of the assembly. So it's on to a bigger and better AMA.

I hope this brief recap of some of my observations and experiences at the recent annual AMA meeting is informative. If anyone has any specific questions, please don't hesitate to get in touch – call, write, E-mail, whatever. Thank you.

GUEST EDITORIAL

Who should live and who should die?

By Joan Beck

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Here's a challenge. Check out this case history. Then decide what the moral should be. For most of human history, people with terminal kidney disease simply died, as their kidneys became unable to filter out harmful substances from the blood and excrete them in the urine.

Then, in the late 1960s, a machine was developed into which the blood could be pumped to be filtered and returned to the body again. The process took several hours and had to be repeated about three times every week. But it worked. And it added years, even decades, to the lives of people suffering from what is known medically as end-stage renal disease.

The very success of dialysis has created a string of emotional, practical and economic problems. And the struggle to pay the ever-growing bill for this lifesaving treatment may provide useful lessons for those debating what the future of health care should be in the United States.

At first, there weren't enough machines or money to save the lives of everyone dying of kidney failure. Making the choice of who would live and who would die was a medical, moral and political agony.

The agony of deciding whom to save and whom to let die was so unbearable that in 1973, Congress ruled that Medicare would pay most of the costs of dialysis and related treatments. It would also cover kidney transplants, which physicians hoped would eventually eliminate most of the need for long-term dialysis.

The program has been highly successful in extending hundreds of thousands of lives of people who would otherwise have died of kidney disease. But the price tag has been far higher than ever predicted.

One key factor is rising costs because of the sheer numbers of people who can survive with dialysis. When the program first went into effect in 1973, there were only about 10,000 beneficiaries. Today, there are about 200,000, and the number will keep growing as the population ages and survival times increase with treatment.

The annual increase in patients isn't "dramatic," the Journal of the American Medical Association said recently. But it is "relentless." Kidney transplants haven't reduced the need for dialysis as much as hoped. About 10,000 kidney transplants are done every year, limited largely by a shortage of organs, but about 50,000 new patients become eligible for treatment.

Costs per person treated for end-stage renal disease range from about \$36,000 annually for young people to \$51,000 for those over age 75. Total spending is projected to reach \$14 billion by 2000.

Many of the money-saving strategies coming into play in health care generally have long been used in the kidney program. The federal government puts a cap

on how much it will pay for dialysis treatments. The rate has never been adjusted for inflation, and the 1993 payment, for example, was worth about 30 percent of the reimbursement in 1974.

Most outpatient dialysis is now done in for-profit centers run by large chains, which are under pressure to earn money for investors. Charges are growing that some of them are cutting corners in ways that may jeopardize patients' health — cutting dialysis time, reusing some equipment, cutting staff-to-patient ratios.

But data is hard to garner and difficult to interpret. Comparisons with other countries are tricky because most countries limit access to treatment for end-stage renal disease by age, health status, accessibility and a few even by political clout.

So which of these lessons can be learned from this extraordinary program?

1. The federal government can, indeed, run a successful, cost-effective program, and we should go for a national health care system. Why should kidney patients get an entitlement that those with cancer or stroke or arthritis or heart disease or other expensive ailments don't?

2. Are we willing to keep pushing health care costs down, even at the risk of jeopardizing patients' care? Can we control corporate pressures to cut corners too much without resorting to malpractice lawsuits and state and federal legislation?

3. The most effective way to hold down the rising costs of the kidney program would be to reduce access to treatment — to ration care, as many other countries do, overtly or covertly. Would that ever be ethically, medically and politically acceptable in the United States?

4. If not, can we accept the fact that health care spending will inevitably escalate because of new technology, an aging population and a growing number of people whose potentially fatal illnesses can be turned into chronic ailments with expensive care?

5. How much money should we try to save by cutting back on research? New drugs and new technology can extend life but add enormously to health care spending — as in the kidney example. But they can also reduce medical costs considerably. Research on bionic kidneys and other new techniques, for example, may eventually result in better care — and lower costs.

6. How much more can we ratchet health care costs down before we begin to ration care — by age, health status or other factors (other than insurance status, as is currently done)? Who would live? Who would die? Who would decide?

7. Will we, as a nation, decide that if we can't hold spending down without rationing or without jeopardizing quality of care, we will be willing to pay the bills, even if the costs rise above \$1 trillion a year and take more than 14 percent of the gross national product? Will we conclude that good health and long life are worth whatever the price tag may turn out to be?



STAHLER
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GUEST EDITORIAL

Kids just a part of smoking battle

By Ellen Goodman

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And you didn't think it was possible for the tobacco image to sink any lower. Now Big Tobacco is the Evil Empire of a John Grisham novel. What next? A Stephen King film with a villain named Philip Morris?

It's been that kind of year. With an anti-smoking president in the White House, with company memos leaking all over the media, with states suing for health expenses and smokers hiding in doorways, the tobacco executives will soon be slinking into work with trench coats over their heads.

The anti-smoking movement is on a roll. But there's one little piece of bad news: The statistics for teen smoking are going up, not down. The Centers for Disease Control and Prevention tells us that the number of smoking teens has risen from 27.5 percent in 1991 to 34.8 percent in 1995. Over the past few years, there has been a subtle shift in public health strategy. Surgeon General [C. Everett] Koop's call for a Smoke Free America has veered into a campaign for Smoke Free Kids.

On the surface, this makes sense. Smoking is not an adult custom, as the tobacco companies like to say; it's a childhood addiction. Ninety percent of today's addicts got hooked as kids. If the companies can't hook the customers today, they will be out of business tomorrow, or at least in a few decades.

This is reason enough to limit the access and the ads, the vending machines and the Joe Camels. If there is one thing everyone can agree on, it's that "kids shouldn't smoke." But there is a paradox in this line of persuasion. The more narrowly we concentrate on kids — the more fervently we insist that cigarettes are not for children — the more we may be making cigarettes the forbidden fruit of adolescence.

Cardiology professor Stan Glantz has been offering warnings about this to his public health colleagues. Talking from the National Tobacco Control Conference in Chicago last week, he said, "The tobacco industry presents smoking as a way to be grown-up. By emphasizing the

kiddie issue, we're just reinforcing the industry's message."

The youth turf is in fact the tobacco companies' briar patch. They love it there. In mid-May when Philip Morris tried its end-run around FDA proposals on marketing to kids, a spokesman said with a straight face, "The time has come to address the issue of underage use of tobacco...."

This was just the latest in a long line of helpful hints on "underage smoking." Since 1979, the tobacco folks have recycled whole flights of "tobacco education messages" that describe smoking as "one of the many activities some people choose to do as adults" such as "voting, driving a car, drinking alcoholic beverages, marriage, having children."

There you go. Linking cigarettes with driving, drinking and sex. What a turnoff!

"It's clear that whatever the tobacco industry suggests is 180 degrees wrong," says Richard Daynard of the Tobacco Litigation Project. "They have figured out what sort of pitch will maximize the adolescent rebellion."

That doesn't mean that we throw in the towel. It means that we keep the aim of the anti-smoking campaign wide and tall — grown-up.

The most successful campaigns across the age spectrum have been formulated against secondhand smoke and addiction. Teens in smoky pursuit of independence are going to be most appalled by the message that they're turning their bodies over to the tobacco companies.

The best thing to do for a not-yet smoker is to show the tobacco companies as they are: nicotine deliverymen. The best way to get a smoke-free kid is to get that smoke-free America.

The first peak of the anti-smoking movement came in the 1960s after Surgeon General Luther Terry's original report. Warning labels were slapped on cigarette packs; ads were pulled from TV; and tobacco was on the defensive. Then Terry announced the goal was to deal with the next generation of smokers — children — and the public health campaign went into remission.

Today at last we're on the winning streak. This time the movement can't be just kids' stuff.

Lawsuit against Aetna dismissed

DECISION: HMO can set standards for its providers, federal judge says. BY KATHLEEN FUREORE

[NEW YORK] On May 29, a U.S. district judge dismissed an antitrust suit filed Aug. 21, 1995, by three groups of New York anesthesiologists against Aetna Life and Casualty Co. The physicians claimed the insurer violated antitrust laws by forcing them to sign contracts unfavorable to them and their patients. Aetna threatened to terminate its contracts with the hospitals at which the physicians worked if the doctors refused to sign contracts for the Aetna Health Plans of New York, the insurer's health maintenance organization, according to Whitney N. Seymour Jr., the physicians' attorney and a partner at the New York law firm Landy & Seymour. The physicians alleged that pressure to contract with the HMO restrained competition among participating providers and contractual limitations would have reduced the quality of care for plan enrollees.

But Judge Denise Cote of the U.S. District Court for the Southern District of New York ruled the providers had no legal basis for their action, because the antitrust law on which they based the case did not apply. Quoting a decision in another antitrust case, Cote wrote that the court must "apply mainstream antitrust doctrine, which allows a buyer or seller freedom to bargain for price."

In addition, her decision stated: "The

plaintiff's principal target here, which is revealed after undressing the plaintiff's complaint from its antitrust robes, is the very concept of managed care. The fact that HMOs have their critics does not obligate the courts to create, through some alchemical process of jurisprudence, a novel application of antitrust laws. The existence of regulatory supervision over the managed care industry, as well as the recent flurry of legislative efforts to control HMOs, persuades this court that judicial restraint in this highly

charged area of law and policy is the best recourse."

"We applaud this decision, which preserves Aetna's ability to establish contractual relationships with providers and hospitals," said Clifford Klima, head of Aetna Health Plans' New York metropolitan market. "This enables us to bring the best value and quality in health care to our members, and derails this attempt by certain providers and their lawyers to undermine managed health care."

Undermining managed care, however, was not the physicians' intent, according to Seymour. The doctors simply wanted the right to an unbiased appeals process for disagreements over appropriate and necessary medical care, which the Aetna contracts did not provide, he said. "The

problem with the contracts Aetna presented and then failed to negotiate was that they provided no vehicle for handling disputes. If a doctor said, 'My patient needs this care' and Aetna said no, it was the end of the matter."

"Quality control issues were the main reason for the lawsuit," said plaintiff Harvey Finkelstein, MD, of Plainview Anesthesiologists at North Shore University Hospital in Plainview, Long Island. "If we felt care was necessary and Aetna didn't, there was no outside arbiter. The insurer's medical director, who is paid by the company, was making all the decisions."

The anesthesiologists plan to appeal Cote's decision, said Seymour. But he declined to comment on her ruling, since the case is pending. ■

Red leaf lettuce labeled culprit in E. coli outbreak

[SPRINGFIELD] The Illinois Department of Public Health has named red leaf lettuce as the culprit behind the recent statewide outbreak of E. coli. Since the end of May, 27 people, most living in the Chicago and suburban areas, became sick from the E. coli 0157:H7 bacteria after eating red leaf lettuce. So far, no deaths have been attributed to the bacteria, but about half of those reported ill with this strain have had to be hospitalized.

"A joint investigation by IDPH, local health departments and the U.S. Centers for Disease Control and Prevention on the

E. coli outbreak has implicated red leaf lettuce served at restaurants and purchased for home consumption at a variety of food stores," said John Lumpkin, MD, IDPH director. "It is unknown whether the lettuce was contaminated while growing or in transit."

Of the 27 Illinoisans who became ill with E. coli 0157:H7 between May 28 and June 14, 18 are from Cook County, four from Winnebago County, two from DuPage County and one each from Kane, Lake and Peoria counties.

The elderly and children under 5 are especially at risk for hemolytic uremic

syndrome as a result of E. coli 0157:H7.

"In recent years, outbreaks of gastrointestinal illness, including E. coli 0157:H7, have been linked to the consumption of foods such as lettuce, tomatoes, alfalfa sprouts, cantaloupe, strawberries and raspberries," Dr. Lumpkin said. The bacteria is present in human and cow feces. "Although we don't know how the red leaf lettuce became contaminated, the lettuce could have come in contact with the bacteria in the field if animal waste was used as fertilizer or if the lettuce came in contact with sewage-contaminated water during shipping and handling."

The contaminated lettuce is no longer in Illinois stores, Dr. Lumpkin said. ■

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ISMIE Update

*Litigation tests the
constitutional
strength of tort
reform*

PAGE 8

Off to see the wizard

To sue a doctor for failing to be the god we wanted strikes me as wrong.

BY ALDEN BLODGET

*From Newsweek, April 1, 1996.
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On April 24, 1990, my father was killed in a Pennsylvania hospital. He was in the third day of recovery from elective reconstructive knee surgery when an error his doctors had made erupted somewhere in his abdomen. Most of his blood vessels ruptured, and he bled to death. His doctors had prescribed too large a dose of coumadin, an anticoagulant used to prevent blood clots.

A few weeks after his death, I flew to Pennsylvania to meet with the two surgeons at the hospital. My family and I needed to know what had happened. Too many unanswered questions lingered. One of my brothers wanted to hire a lawyer and turn him loose but had agreed to wait until he knew the results of my meeting.

At noon, I stood before the hospital, a solid collection of brick and concrete and glass rectangles – a massive promise of competence and power. I felt small and nervous. I tried to imagine my father, who hated hospitals and was a grumpy and ill-tempered patient, as they rushed him back again to the operating room. I had been told that one of the doctors walked at his side and held my father's hand, and I wondered if Dad had been frightened.

I imagined the surgeons opening his abdomen and standing transfixed and impotent before the hopelessness of all that damage. My mother had called me from the hospital to say that they'd sewn my father up and wheeled him to a room where he lay unconscious and dying. There had been too much bleeding to stop it.

As I stood looking at this imposing building awash in the noon sun, I couldn't shake the image of Dad's small body lying alone in the dark somewhere inside. How could they open him, recognize the problem and



not fix it? This was a hospital, and he had been here, not dangling from the end of a 911 call somewhere in the wilderness. It was as absurd as a fire station burning down.

I reached inside my jacket and touched the folded list of questions I wanted to ask, reminding myself that this hospital was now going to answer to me. I felt no reassurance. The hospital looked just as huge, and I felt no bigger.

My memory of the two hours I spent with the doctors is a jumbled collection of impressions wrapped in sadness and a surreal haze. The doctors seemed young, in their late 30s. They were energetic, sincere and intelligent. I was struck by their promptness and the apparent open-endedness of our meeting. I guess we all sensed the distant thunder of litigation.

They led me to a comfortable room – wood paneling, polished wood table, padded chairs – where we were served lunch.

My father had once told me a story about having lunch with a doctor friend in a similar room. When they entered, a few doctors were eating around the table and discussing a model of an amputated leg that stood amid the napkins and plates. While the two doctors answered my questions, I felt my father's ghost settle over our conversation. I wondered if I was moving closer to the truth that fluttered elusively through the shadows of their explanations.

As they spoke, I understood the reason Dad had chosen and trusted them to repair his knees. He'd always insisted on finding the best people for any job – the best lawyers, teachers, mechanics, doctors. His vast network of professional friends had led him to these surgeons. And they were clearly good. They guided me carefully through the details of my father's last few days – the blood clot that appeared in a lung, the difficulty of determining quickly the level of

coumadin in the blood, the unanticipated changes in my father's chemistry since an earlier knee operation.

When they described the sudden jump in his coumadin count and their scramble to reduce it, I noticed one doctor swallow. It was a moment in the Emerald City. The tremor of his Adam's apple shook the curtain aside to reveal the small, frantic man behind the image of the wizard. I was in a fancy room in a big building, but these were not gods or magicians. They were men – imperfect and fallible – frightened to appear so in a society that expects perfection and infallibility from its professionals, especially its doctors.

These men were just like the rest of us. They'd spent years working hard to become competent in a field they care deeply about, a field that despite two or three thousand years of development is still a mixture of marvels and mystery. They hadn't been

negligent or incompetent. They'd used the complex and dangerous tools of their craft as carefully as they could, guided by knowledge and understanding based on previous use of the same tools. They had improvised as intelligently as they could when the results failed to conform to previous experience. They'd made mistakes that they could see only in hindsight, the perspective from which society makes its judgments. In hindsight everything is obvious.

IN THIS ERA of lawsuits and other lotteries, I am sure I could have become a millionaire by suing my father's doctors and the hospital – assuming my lawyer would have shared the award with me. But I didn't. I think I understand the reason. It wasn't that I wasn't angry with the doctors, that I didn't want revenge or someone to pay for my pain. I'm not so gullible that I can't recognize the crooks and quacks that move among us. It was simply my realization that we expect too much from each other. We refuse to accept that we make mistakes, that even the best of us screw up.

Don't misunderstand me. I know that forgetting the lettuce in a Big Mac doesn't compare to making an error that costs a life. The stakes are higher in an operating room. Nor am I opposed to lawsuits that seek to punish those who hack off the wrong leg or knowingly sell products laced with danger. But to sue someone for failing to be the god we wanted strikes me as wrong.

Why is it that we know so little ourselves yet expect so much from others? We refuse to recognize the flimsy curtain that separates the intention from the result, the image from reality. Andre Agassi and the Wizard of Oz may believe that "image is everything," but most of us ought to know that we're just folks from Kansas flying by the seat of our pants and doing the best we can. ■

©Mike Wimmer

Litigation tests the core of tort reform

Although some plaintiffs and their lawyers try to chip away at the

BY KATHLEEN

The debate on the constitutionality of the tort reform legislation Illinois lawmakers passed in March 1995 has reached the state's highest court for the first but probably not the last time. In June, the defense in *Kunkel vs. Walton* appealed Macon County Judge Scott Diamond's May 6 decision that declared modifications to the Petrillo doctrine unconstitutional. Although that is the first direct appeal of a reform-related decision to the Illinois Supreme Court, attorneys predict others will follow, since more than 70 lawsuits challenging various aspects of the legislation have already been filed throughout Illinois, said a defense attorney in the *Kunkel* case, Robert Chemers of Chicago's Pretzel & Stouffer.

The provision now before the high court states that patients who file medical malpractice suits must authorize the release of their medical records to the defendant within 28 days. In addition, it allows defense attorneys to confer with defendant physicians or any physicians who have treated plaintiffs before those physicians testify in a deposition or trial. If plaintiffs fail to comply with the release of records, defendants can seek a court order to obtain them or move to have the case dismissed. The Petrillo doctrine, established in 1986, precluded defendant and treating physicians from communicating with defense attorneys unless the plaintiff expressly consented, and it prohibited such communication outside the presence of the plaintiff's attorney. However, it allowed plaintiff attorneys to informally discuss a case with a treating physician. ISMS supported the modification, which "speeds up the litigation process and makes it less costly," said ISMS General Counsel Saul Morse.

"The plaintiff [in *Kunkel*] says the provision is unconstitutional on several grounds, and the trial court agreed," Chemers explained.

According to Diamond, the provision is special legislation and invades the plaintiff's privacy. His order said the legislature "has infringed [on] the court's judicial rule-making power as to discovery." He also wrote that the modified Petrillo language violates the section of the state Constitution "relating to unreasonable invasions of privacy, because the requirements of discovery are so wide into a person's medical history, which may have no relationship to the person's present complaint," he wrote. In addition, he ruled that "the required authorization of release of medical information is overly coercive and prevents a plaintiff from making a free and consensual decision."

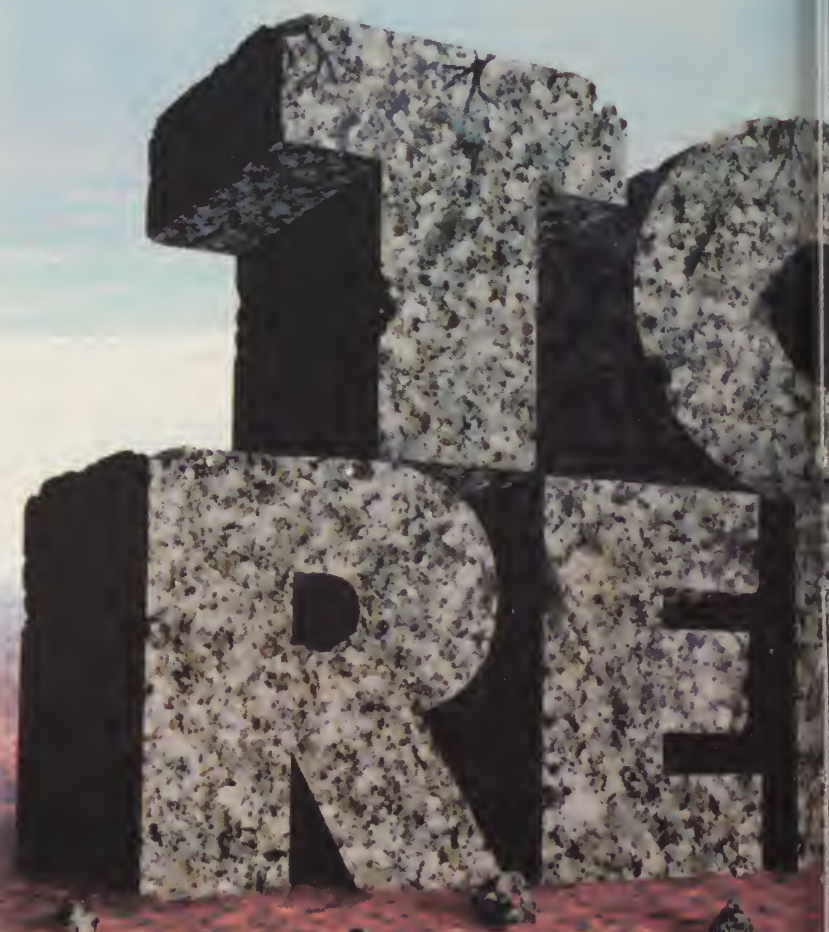
A decision in the *Kunkel* case is not expected until next spring, according to Chemers.

Although Chemers said "just about every provision that applies to medical malpractice is being challenged," he added that the Petrillo language is an issue in many of the suits filed in county courts. That's because the doctrine stemmed from an appellate court decision "that has resulted in numerous other decisions, not one of which ever was reviewed by the [Illinois] Supreme Court. So when the Petrillo issue became the subject of a statute, it became a natural focus [of litigation]."

Defense attorney David Sinn of Heyl, Royster, Voelker & Allen in Peoria also said cases involving the Petrillo pro-

vision have surfaced "because of where the issue falls in the [litigation] process. When a case is filed, you more quickly get to the issue regarding the manner in which defense attorneys obtain information. The cap issue isn't raised until you get to trial, so those challenges will come later."

The Petrillo decisions rendered so far are divided and have made procedures confusing, at best, for physicians and their attorneys. "There has been a tremendous split in authority around the state," Chemers explained. "Things now are in a state of chaos, and it depends on the county in which doctors are sued [as to whether] they get the benefit of the statute." The courts in Macon County, for example, would probably follow Diamond's decision in *Kunkel*, he said. But in Peoria County a decision would more likely be made in a defendant physician's favor because of Judge John Barra's June 19 order declaring the Petrillo reform constitutional. The plaintiff waived the right of privacy "by



Gary Cox

Constitutional strength reform

Under the 1995 law, the Illinois Supreme Court will be the final judge.

IN FUTURE

the filing of this lawsuit putting the physical condition of the deceased in issue," Barra wrote. "No conflict exists between the relevant statutes and Illinois Supreme Court rule. Nothing in the new rules on discovery reveals any conflict between the statute and those rules."

Cook County Judge Kenneth Gillis was the first to find the Petrillo provision unconstitutional in a decision handed down Feb. 27. Morse said he is aware of eight other decisions on Petrillo, "which split relatively evenly, with five decisions striking the language as invalid and four upholding the language. They are from counties as diverse as Champaign, Macon, Winnebago and Ogle, just to name a few."

"That's why this should be appealed – so the Supreme Court can speak to the issue, so there's uniformity and consistency in the application of the law," Chemers said. Until the high court reaches a decision, plaintiff attorneys will be able to "forum shop," he added. "You can venue a case in

more than one county. So [plaintiff attorneys] can try to find a county they feel is most favorable to them."

Judges have ruled on other tort reform provisions, too. On May 22, Gillis issued a memorandum opinion declaring unconstitutional the \$500,000 cap on noneconomic damage awards in civil liability lawsuits, which was one of ISMS' top priorities in the fight for tort reform. Gillis called the provision "special legislation" and wrote that he did not believe it had "a rational basis, either to distinguish between economic or noneconomic damages, or to limit noneconomic damages, or to limit them for persons (or estates) that suffer catastrophic amounts on noneconomic damages."

Attorneys said cases filed in connection with the Fox River Grove bus accident that killed seven teens last fall are expected to challenge the cap. "They would be the natural ones," Chemers said. "In the past, those cases would have resulted in whopping verdicts made up of largely noneconomic losses."

In February, Gillis also declared unconstitutional the provision stating that hospitals are not vicariously liable for the actions of physicians they do not employ. He said it violates the state Constitution's special legislation and equal protection clauses because it "only attempts to eliminate the doctrine [of apparent agency] for medical, hospital or other healing art malpractice." However, Gillis upheld as constitutional a provision that requires plaintiffs to provide the name and address of the physician or other health care professional who reviews a case and certifies its merit. Nothing in related cases reveals anything "that hinges around the nondisclosure of the medical health care professional's identity or anything that would ban disclosure," he wrote.

Ultimately, all the issues being challenged will likely end up before the Illinois Supreme Court, according to the attorneys. As Sinn noted, "These challenges were absolutely expected. It's not a surprise at all. It's really part of the process. Any time you change the law, that change will be subject to challenges down the road."

The Kunkel case, in fact, is just the first step in what Chemers predicted will be a "long process."

"If there's anything unfortunate about the Kunkel case," Chemers continued, "it's that it only deals with the Petrillo issue, so the court doesn't get to cherry-pick. It doesn't get to look at the entire tort reform picture." But seven cases were consolidated for the Gillis decision, and that could give the high court the chance to do just that, he said. "If and when the consolidated cases Judge Gillis is hearing get to the Supreme Court, the court will be able to cherry-pick. They'll be able to say, 'The decision on this provision is right; the one on this one is wrong.' There may be concessions and some bargaining. But the [plaintiff bar] won't come out with a clean sweep."

Sinn noted that most constitutional challenges before the current Supreme Court have failed. Consequently, plaintiffs will "need to get an appellate court to go along with their point of view," he said. "This Supreme Court is prone to affirming appellate court decisions. It perceives its role to be adjudication and not legislation. The court has been very good at staying away from the temptation to act as a super legislature. It lets the people speak through the legislature." ■



Illinois EMS

(Continued from page 3)

need to be better prepared to treat pediatric patients. The assessment also showed that just 63 percent of emergency physicians have completed formal pediatric resuscitation training, that only 15 percent of EMS agencies conduct pediatric injury prevention activities, that just 41 percent of hospitals offer pediatric-specific public education programs and that 33 percent of the 400 children seriously injured at school in 1994 were not transported via emergency vehicle to the hospital.

"Nobody feels particularly comfortable with kids [in emergency situations], especially in settings where [the treating providers] don't see them a lot," Gutfeld said. "In outlying areas, for example, there are very few emergency physicians, so emergency coverage is usually provided by FPs or other specialists. So with procedures like child intubations, they don't have as much chance to feel comfortable."

"Only 10 percent of prehospital [EMS] runs are for children, and an even smaller percent [of those children] are critically ill," Dr. Rosenberg explained. "Paramedics aren't seeing kids as fre-

quently as they do adults, so their level of comfort is less." Establishing an airway in a small child, for example, creates more anxiety and is more difficult to do when the physician has never performed the procedure or has done so infrequently, Dr. Rosenberg said.

To remedy those kinds of problems, the Illinois EMSC program is using grant money to help fund pediatric-specific courses for physicians, nurses and EMTs. "We're aiming for a level of skill so [providers] will be able to appropriately identify the emergency, resuscitate and stabilize the patient, and recognize if there is a need to transfer the child to a facility that can [more] appropriately care for the patient's care needs," Gutfeld said.

Such courses will help providers assess the status of children with chronic or rare conditions — a task that can be tough for providers with little pediatric experience, said Ron Lee, MD, an emergency physician and chief investigator for the EMSC grant. "Once you're faced with a very rare situation, you have to be able to quickly assess and treat [that child]. These courses will focus on critical situations."

Lyons said the Illinois EMSC program will join the Kiwanis organization this month to sponsor injury prevention programs in communities statewide. "We're identifying not only that physicians should be able to provide better care, but also that we need to create a safe environment," Dr. Lee said. "Kids on a playground may not be safe, and a mom needs information to be able to assess that."

The next step will be for the program administrators to link with databases from such sources as the IDPH Trauma Registry and the Illinois Department of Transportation's Crash Report to access accident report and death certificate information. "This will enhance our ability to look at the entire picture," Lyons said.

"We want to be able to tell communities where and how injuries and deaths are occurring," Gutfeld added. "Some areas' concerns about homicide might be legitimate, but in other areas there may be no reason for those fears, because most deaths are from motor vehicle accidents. When you're looking to put on prevention programs, that kind of information will help improve the efficacy of the program." ■

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological Basis of Therapeutics 6th ed., p. 176-188. McMillan.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982. Rev. December, 1984.



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HCFA approves

(Continued from page 1)

"well into 1997," said IDPA spokesperson Dean Schott. Some 180,000 recipients have enrolled in one of nine HMOs under the existing system, which lets patients select an HMO or fee-for-service provider but does not default recipients into a capitated plan if they fail to choose a plan or provider. Current managed care participation is primarily in the Cook County area.

When MediPlan Plus is implemented, marketing and enrollment procedures will change. For example, door-to-door marketing by HMOs will be prohibited, Hovanec said.

The impending changes will affect physicians as well as patients. Participating providers, for example, will be required to sign a gatekeeper agreement, Hovanec said. "Right now, clients can go to Dr. Jones in the morning and Dr. Smith in the afternoon, and both will be paid. Under MediPlan Plus, one physician will be responsible for authorizing all of a patient's care. Others won't be paid if the patient wasn't referred to them by the gatekeeper." There had been a gatekeeper concept under the Healthy Moms/Healthy Kids program, but no gatekeeper provision has been in force since June 1995, Hovanec said.

Hovanec stressed that "any physician licensed to practice medicine in all its branches" will be eligible to serve as a gatekeeper in the new system. "We're not defining who a primary doctor is. We believe there are cases where a cardiologist, for example, is most appropriate. It is up to the client to choose the doctor and for the doctor to determine if he or she is the appropriate provider to care for that patient." IDPA, however, will not force a physician to accept a recipient "as long as it's not a case of discrimination or a violation of the Civil Rights Act," he said.

ISMS and IDPA are working out specifics of the new physician contracts based on the waiver's requirements. The department is also refining details regarding the pediatric and mental health carve-

out provisions, according to Hovanec. "During the next couple of months we will bring these issues to rest," he said. Before the program can be implemented, IDPA must provide HCFA with a timeline, protocols for program development and implementation, requests for proposals to managed care entities, and a patient education plan and materials, Schott said.

"Over the past two years we have worked with the state and will continue to work with them in refining elements of the program," said John Schneider, MD, Chairman of ISMS' Third Party Payment Processes Committee. "There are still issues that need to be resolved. But we're looking forward to resolving them successfully so we can ensure that Medicaid patients are fully informed and able to make informed decisions about the options available to them under MediPlan Plus."

Regarding the prospect of federal Medicaid reform, Hovanec said he believes "it is dead until after the election." But MediPlan Plus will move forward whether or not federal reform is achieved, he added. "Even if there is some kind of federal reform, we would still be pursuing a similar model [to MediPlan Plus]. Federal reform probably wouldn't affect the delivery system or the physicians. Who is eligible and how they become eligible is what would likely be affected."

"IDPA's goal is to introduce more managed care into the system," Schott said. "With or without federal reform, we will continue to do that." ■



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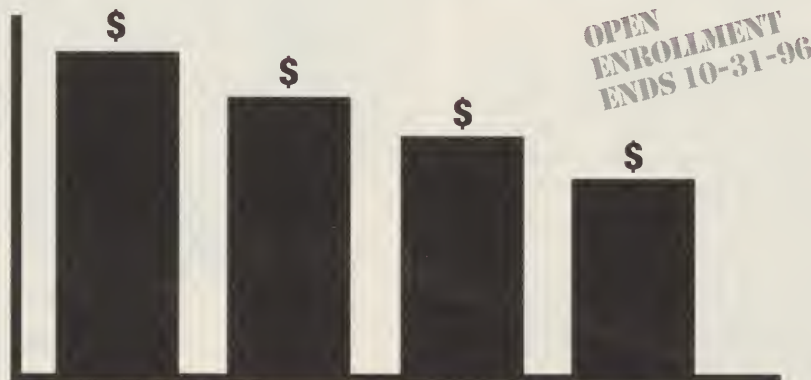
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Illinois Medical PSO

(Continued from page 1)

which is the sole holder of the Illinois Medical PSO's common stock, has already named seven Board members: Dr. Fesco; Dr. Sprang; Dennis Brown, MD; Alfred Clementi, MD; Harold Jensen, MD; Ronald Ruecker, MD; and Ronald Welch, MD.

Bank offers stock financing

The First National Bank of Chicago will help physicians finance their purchase of preferred stock in the Illinois Medical Physician Services Organization Inc. through its First Line of Credit, according to Edward Fesco, MD, chairman of the Illinois Medical PSO Board of Directors.

The bank will determine the credit-worthiness of each physician who applies for financing. As with any loan agreement, borrowers will be responsible for all fees and payments.

Physicians interested in applying for financing can contact First Chicago at (312) 732-9502. ■

Explaining the physician-only requirement of the stock offering, Morse said: "We want to make sure the Board is elected by doctors and the Illinois Medical PSO is directed by doctors. We're limiting the investment eligibility to Illinois physicians so [the offering] can be exempt from cumbersome and expensive federal securities regulations." An exemption from securities registration is available for entities that conduct business primarily in a single state and offer their securities only to investors in that state, he said. The capital offering had to be registered with the Illinois secretary of state because no similar exemption for an intrastate offering is available at state levels, Morse added.

Projections are that launching the Illinois Medical PSO will require \$5 million and carrying it into its third year of operation will demand another \$10 million, according to Morse.

The Illinois Medical PSO will emphasize fair pricing over corporate profits and capital reinvestment and growth over cash dividends, Morse explained. Investors will profit from the PSO's planned commitment to growth and operation as a physician-first company, which, unlike some nonphysician-operated management service organizations, will tailor its services to the specific needs of each physician client. Consequently, the purchase of stock will help ensure that Illinois doctors have opportunities for clinical, professional and economic growth in the burgeoning managed care marketplace, Dr. Fesco said. "Your investment will ben-

efit you and the entire medical profession. It will help physicians manage managed care for the benefit of our patients."

"Physicians have been looking for more than monetary returns," said John Ray, interim chief operating officer of

the Illinois Medical PSO. "They have to see this as a strategic investment — an investment in the infrastructure that will be required to sustain the autonomy of the medical profession in the future. It's nothing less than that." ■

NIH panel urges wider use of Pap tests, education

[BETHESDA, MD.] A National Institutes of Health panel in May recommended wider use of Pap tests, saying increased screening could prevent all of the 15,000 new cervical cancer cases diagnosed in the United States each year. The panel said it's especially important to reach women who live in rural areas or are over 65, uninsured, poor or members of ethnic minorities — particularly Hispanics and older blacks — since those groups have lower rates of screening and higher rates of the disease.

One study showed that 50 percent of women over 60 had not had a Pap test in three years, even though 25 percent of invasive cervical cancers and 41 percent of deaths occur in women over 65. Many physicians don't stress the importance of Pap tests to their older patients. Half of all newly diagnosed cervical cancer patients have never been screened for the disease, while 10 percent have not had a Pap test in the past five years.

"If we could reach all the women in this country who are not getting regular Pap tests, we could eradicate this form of cancer," said Allen Lichter, MD, panel

co-chairman and chairman of the Department of Radiation Oncology at the University of Michigan Medical Center in Ann Arbor.

The panel also emphasized the importance of educating health care providers and adolescents about the strong causal link between the sexually transmitted human papillomavirus and cervical cancer. That, along with discouraging early sexual intercourse, encouraging the use of barrier contraceptives and developing a preventive vaccine could help prevent HPV infection, the panel said.

The 13-member panel issued its findings at the NIH Consensus Development Conference on Cervical Cancer convened by the National Cancer Institute and the NIH Office of Medical Applications of Research. The event was co-sponsored by the Centers for Disease Control and Prevention, along with the NIH's National Institute of Nursing Research, the National Institute of Allergy and Infectious Diseases, the Office of Research on Minority Health and the Office of Research on Women's Health, according to information from the NIH. ■

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Medicaid seminar compares state managed care systems

PERSPECTIVES: Experts share stories about marketing to Medicaid populations.

BY KATHLEEN FURORE

[CHICAGO] National managed care experts and representatives from Massachusetts, New York and Tennessee shared information about marketing managed care to Medicaid recipients at a May 28 program held at the University of Chicago Downtown Center. Sponsored by the Illinois Department of Public Aid's Medicaid Managed Care Subcommittee and the Chicago Health Policy Research Council, the program aimed to help those involved with or interested in MediPlan Plus – Illinois' plan to move most of the state's Medicaid recipients into managed care – learn from what other states have done, according to program sponsors.

Neva Kaye of the Medicaid Managed Care Resource Center at the National Academy for State Health Policy in Portland, Maine, opened the seminar with an overview of how states have approached Medicaid managed care. Primary goals are enrolling people in HMOs and ensuring that enrollees understand managed care

before they enroll, she said.

The nature of the program – whether it's voluntary or mandatory – impacts which goal is emphasized, she noted. Voluntary programs emphasize enrollment, while mandatory programs focus on making sure enrollees understand the system, Kaye said. Under MediPlan Plus, Medicaid recipients will be able to select an HMO or fee-for-service gatekeeper, but those who fail to choose will be defaulted to an HMO.

The party doing the marketing also influences marketing and enrollment, Kaye explained. "When plans are responsible for marketing, they're focused on enrolling people into their plan and perhaps don't do as full a presentation of a person's options as a third party would."

Minnesota, for example, contracts with county governments to do enrollment and prohibits direct marketing by plans in its mandatory program. But in Maryland, where the program is voluntary, the plans handle most of the enrollment process, Kaye said.

She also noted that the states she surveyed relied more on written mate-

rials and phone hot lines than on HMO report cards and consumer groups for client education and enrollment. Information was also dispersed at health fairs, neighborhood forums, outpatient sites and federally qualified health centers and clinics, she said.

Kaye went on to address how states can monitor their managed care programs. "You have to not only think ahead about what you want the plans to achieve, but design a system that's going to enable you to catch when something is going astray that you don't expect. And the thing that is perhaps most key to making a monitoring process work is a good contract."

Contracts should clearly spell out the state's requirements for the health plans and the specific responsibilities of those plans, she said. In states that allow door-to-door marketing, for example, contracts often designate topics to be covered in the marketing presentation, qualifications and compensation plans for the marketing representatives, and even the kind of training the reps must complete. Typically, contracts also require preap-

proval for all marketing activities and materials, include standard reporting requirements and reserve the state's authority to interview or survey enrollees and to pose as potential enrollees, Kaye said.

Following Kaye's presentation were two panel discussions. In the state policy-makers' discussion, Judy Fleisher of the Health Benefits Management Program of the Commonwealth of Massachusetts Division of Medical Assistance and Peggy Quinn, president and CEO of Harmony Health Plan of New York, shared the specifics of their states' Medicaid managed care programs. In the consumer advocate discussion, Susan Sherry of the Center for Community Health Action in Boston and Tony Garr of the Nashville-based Tennessee Health Care Campaign described the role played by consumers and community advocates in implementing state-run programs.

"For special populations, special issues come up, and you need to work with consumer advocates," Sherry explained. Special provisions were made for Haitian enrollees in southeastern Massachusetts, for example, thanks to advocates' input. Basing plan assignments on those recipients' locations did not make sense, since no Haitian providers practice in that area, Sherry said. ■

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Hearing focuses

(Continued from page 1)

was told by an HMO representative that unless she chose an HMO, she would lose her public aid benefits. Her sister was also asked to sign a form to prove the marketing representative had made a presentation, but she later learned that her signature had enrolled her in that HMO, Washington said.

Enrollee Maria Esquivia reported her HMO offered prenatal and delivery services only at a hospital so far from her home that she had to take two buses and travel an hour each way to reach it.

Representing the U.S. Department of Health and Human Services, Regional Director Hannah Rosenthal said she was "deeply disturbed" about the reports of marketing abuses by HMO representatives.

Forum panelist Robert Owens, MD, medical administrator at the Englewood Neighborhood Health Center, said, "[My] main concern is how the impending changes in Medicaid programs and the aggressive HMO recruitment currently taking place in our communities will affect the continuity and quality of patient care."

In a July interview with Illinois Medicine, John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee, said marketing practices are critical from a patient care standpoint. "If, because of misleading marketing, a patient signs up for a plan that is in an inaccessible location or that doesn't include the physician who has been providing care, that can disrupt continuity of care."

"We believe the best defense against marketing abuse is a well-informed client," said Linda Renee Baker, IDPA's assistant director. Since February, IDPA has stationed 96 health benefits representatives in all 24 Chicago-area public aid offices to help enrollees in the Aid to Families with Dependent Children program make informed choices, she explained. These reps were recruited, hired and trained under a contract between IDPA and two community-based social service agencies. Of the 96 health benefits representatives hired by the contractors, 38 percent are themselves public aid recipients and 25 percent are bilingual, Spanish-speaking individuals, Baker said.

IDPA has also instituted the Neighborhood Education initiative, a grassroots approach to providing information about health care options at community meetings. More than 250 such meetings have been conducted in churches; Women, Infants and Children program sites; schools; and housing projects throughout Cook County to help clients understand their health care choices, Baker said. The community gatherings focus on the importance of preventive health care, the benefits of choosing a "medical home" for continuity of care and the choices available under Medicaid.

In addition, IDPA has activated a toll-free hot line, (800) 226-0768, which physicians and enrollees can call to report marketing abuses. Robert Miller, IDPA's inspector general, said that of the 113 allegations of HMO marketing abuses his department had received since November 1994, only 50 incidents warranted investigation. So far, only 13 of those cases have been found to have involved forged signatures or misrepresented plans, and those marketers have been banned from working for any HMO in the Medicaid system, he said.

Miller also noted that some recipients

may be reluctant to report marketing abuse and that IDPA is asking clinic directors and physicians for such information.

In an interview July 12 after the waiver was approved, Hovanec discussed how MediPlan Plus will affect HMO marketing. Recipients will enroll in HMOs with the assistance of independent health benefits representatives, not the HMOs themselves, he explained. Direct solicitation and door-to-door marketing by HMOs will not be allowed once MediPlan Plus is implemented, which Hovanec estimated would happen by fiscal year 1998 at the earliest. He added that IDPA will "work actively" with ISMS and other groups to

design managed care services that will be provided by Illinois physicians.

Illinois would do well to learn from the marketing and enrollment experiences of other states, said Whitney Addington, MD, president of the Chicago Board of Health. He said that at a seminar co-sponsored by IDPA's Managed Care Subcommittee, he heard reports that New York was considering a ban on in-home marketing and will move toward a system that uses independent brokers with no HMO affiliation to educate and enroll recipients.


Addington said that Massachusetts uses an enrollment broker and prohibits

all direct marketing, "a model that holds great promise for informed patient choice"; Washington state has banned direct marketing; and California is moving toward an independent enrollment and education process.

Durbin said responsible HMOs would want the terms of their plans explained adequately. Representing the 19 members of the Illinois Association of HMOs, in whose programs 2.3 million Illinoisans are now enrolled, Robert Currie, president of Unity HMO of Illinois, said his association shares concerns about marketing abuses. "The enrollment process can and should be educational."


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PAGE 8

Illinois Medicine

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AMA approves tenets of Study of Federation

PAGE 6

Hospital appeals in Rockford corporate practice of medicine case

DECISION: Judge rules contractual noncompete clause to be unenforceable.

BY KATHLEEN FURORE

[ROCKFORD] On July 12, Rockford Memorial Hospital appealed the June 7 decision by Winnebago County Associate Judge Gerald Grubb that rendered unenforceable a noncompete clause in the hospital's contract with reproductive endocrinologist John Holden, MD.

"The central reason we are appealing this case is that it will guide our program development," said Patricia King, vice president of legal affairs and general counsel for the hospital's parent, Rockford Health System. At issue, she said, is whether the hospital should continue investing its resources in recruiting, developing and maintaining physician practices. "Is it worth investing in such programs if the physician is allowed to take the benefit of that investment and set up a competing practice in our market?" King said.

The contract in question, signed by Dr. Holden in May 1993, barred him from practicing reproductive endocrinology in Rock County in Wisconsin and Winnebago, Boone, Ogle, Whiteside, Lee, DeKalb, McHenry, Stephenson and Kane counties in Illinois "for a period of two years after termination of expiration date" of the contract. But when Dr. Holden left Rockford Memorial in early 1996, he filed a motion asking the court to declare the noncompete clause unenforceable, according to his attorney, Richard Haldeman, of Haldeman & Associates in Rockford. That motion contended Rockford Memorial "has no authority to practice medicine, no authority to employ physicians and, thus, the noncompetition clause in the employment agreement is unenforceable."

Dr. Holden also charged that Rockford Memorial was in breach of contract because the hospital did not grant him the authority it promised when he was recruited from the University of California at San Diego, where he completed a fellowship in 1993, Haldeman said. "He was encouraged and enticed by the program and the ability to be director of the department of endocrinology and to develop a program in reproductive endocrinology. But he was not allowed to exercise the power he should have had, and the hospital delayed making a financial commitment to the program," Haldeman explained. Rockford Memorial also "took away Dr. Holden's directorship and put two other people in his place," he added.

Dr. Holden said he was so
(Continued on page 11)



John Patsch/Copley News Service

JULY WAS NOT a good month for many Illinoisans, as heavy rains made rivers of roads like this one in Lockport and caused 15 counties to be declared state disaster areas. Public health initiatives in flooded areas included immunizing for tetanus.

Physician-driven care is goal of Kaiser, Illinois Medical PSO

PROFILE: Kaiser Permanente pioneered a concept that the PSO shares today. BY KATHLEEN FURORE

[OAKLAND, CALIF.] Illinois physicians and their peers in most other states are working hard to adapt to an increasingly managed care marketplace. But managed care is not a new concept. It dates back to 1933 when surgeon Sidney Garfield, MD, established a prepaid group practice health plan for the construction workers building an aqueduct in the Mojave Desert to carry water from the Colorado River to Los Angeles. Employees contributed five cents per day in return for comprehensive medical care that emphasized prevention, and physicians providing their care received a set, steady income.

Five years later, Henry Kaiser, the contractor for the Hoover and Grand Coulee Dams, asked Dr. Garfield to create a similar program for Kaiser employees working on the Grand Coulee. In 1942, the medical plan was offered to Kaiser employees

working at his shipyard on the West Coast, according to historian Rickey Hendricks' book "A Model for National Health Care: The History of Kaiser Permanente," published in 1993. In 1945, the Kaiser Permanent Health Plan became a nonprofit public benefit corporation. In 1955, the group formed its first three regional organizations in Northern and Southern California and in the Northwest. Following that was expansion into Hawaii in 1958 and Ohio in 1969. Today, the nationwide Kaiser Permanente family includes 7 million members, more than 9,300 physicians, 28 medical centers and more than 265 outpatient medical facilities, according to Kaiser Permanente spokesperson Ron Treleven.

Henry Kaiser and Dr. Garfield "pioneered a medical program that changed the face of U.S. health care," Hendricks
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INSIDE

State allows
physician
discretion in
timing of MMR2



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Missouri Blues sues state

AT ISSUE: Insurer challenges demand for millions related to for-profit subsidiary. BY KATHLEEN FURORE

[ST. LOUIS] On July 1, Blue Cross and Blue Shield of Missouri sought summary judgment in a lawsuit filed May 13 against Missouri Director of Insurance Jay Angoff, the Missouri Department of Insurance and Missouri Attorney General Jay Nixon. The suit sought a declaratory judgment that the insurer followed all applicable rules and regulations when it reorganized, created the for-profit subsidiary RightCHOICE Managed Care Inc. and offered 20 percent of RightCHOICE stock on the New York Stock Exchange in 1994. The suit also asked the court for a permanent injunction prohibiting Angoff from refusing to renew the insurer's license or to take other administrative actions that would pressure the Blues into paying assessments or fees because of the reorganization, according to information from

the insurer. A circuit court judge issued a temporary restraining order May 21.

The suit stems from the MDOI's demand that Blue Cross and Blue Shield of Missouri pay the state up to \$500 million because of allegations the insurer converted almost entirely from nonprofit to for-profit status when it created RightCHOICE. The department maintained that the Blues' actions were not in accordance with the final approval for reorganization and that the insurer did not disclose plans to reinsure existing MediGap policies with a wholly owned subsidiary of RightCHOICE.

But the Blues said that those contentions are false and that it remains "a financially sound, independently viable and active health services corporation," according to the lawsuit. The
(Continued on page 12)



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Cook County launches bicycle helmet safety program

[OAK PARK] To combat the number of serious injuries and deaths associated with bicycle and in-line skating accidents, the Cook County Department of Public Health and the Forest Preserve District of Cook County this summer started a bicycle helmet safety program. "Heads Up! For Trail Safety" was launched in June at the Tinley Creek, Salt Creek and Busse Woods bike trails in Cook County.

"This program has been designed to increase the use of helmets by bicyclists and rollerbladers on forest preserve trails to prevent serious injuries caused by collisions and other accidents," said Cook County Board President John H. Stroger Jr. "We need to make recreational activities safer for Cook County residents."

According to the Cook County Department of Public Health, 844 trauma injuries were related to bicycle accidents in Illinois last year, costing \$8.6

million in health care costs alone. Seventeen percent of patients suffering trauma were admitted to intensive care units.

"Each year, nearly 1 million children nationwide are treated for bicycle-related injuries in hospital emergency rooms," Stroger said. "In 1995, 11 people died as a result of these type of accidents in Illinois, and four of these people were from Cook County. Also, it's important to remember that 37 percent of these bicycle accidents involved children under the age of 15."

The Illinois Department of Public Health reported that three out of four of all serious injuries and deaths stemming from bicycle collisions involve head injuries. Using bike helmets, however, reduces total head injuries by 85 percent and the risk of brain injury by 90 percent, according to IDPH.

With the "Heads Up!" program, Cook County Forest Preserve police issue safety

citations and gift bags to people wearing helmets. The bags include discount coupons for various products from the program's corporate sponsors.

"This program has shown how both government and private businesses can work together to ensure the safety of our citizens," Stroger said. "Bicycle helmets save lives. We want to see bike enthusiasts have fun and stay healthy. That's what these helmets are designed to do."

Bikers and in-line skaters not wearing helmets receive educational materials on helmet use and discount coupons for helmets. The materials explain how helmets can help prevent head injuries that sometimes lead to permanent disabilities and even death.

According to Stroger, the "Heads Up!" program also imparts to parents the importance of teaching their children to wear helmets. "Parents need to insist that children wear their helmets on every ride. [A child's] wearing a helmet should begin with the first bicycle."

ISMS encourages statewide bicycle safety efforts for children, including increased use of helmets. ■



Matt Ferguson

A FIREFIGHTER assists the "victim" of a simulated school bus accident as part of a disaster drill in Naperville last spring. The city's fire and police departments helped take more than 20 people to Edward Hospital for "treatment."

Camp COCO helps sick kids experience child's play

[SPRINGFIELD] Illinois children suffering from cancer and other blood disorders were treated to a weeklong camp in late June as part of a project sponsored by the Southern Illinois University School of Medicine in Springfield. The 11th annual

Camp COCO hosted more than 85 campers, ages 6 to 17, at the Easter Seal Camp on Lake Bloomington.

"Camp COCO allows children to take a vacation from their chronic concerns and worries attributed to their med-

ical conditions," said Thomas Loew, MD, assistant professor of pediatrics at the SIU School of Medicine and the camp medical director. "They're here to enjoy a week of activities just for the purpose of having fun. These children engage in the same activities that other healthy campers do, such as swimming, horseback riding, arts and crafts, and fishing. The only difference is that we have a medical staff to ensure the children's safety."

The medical "counselors" include SIU's pediatric staff members, who spend the week not only caring for patients but also getting to know them in a more relaxed setting, Dr. Loew said. Also staffing the camp are health professionals from Methodist Medical Center and the St. Jude's affiliate in Peoria and St. John's Hospital in Springfield.

Many of the campers, who have already undergone treatment for cancer, attend Camp COCO every year. Their presence, Dr. Loew said, gives hope to first-time campers who are just beginning treatment. "The wonderful thing about Camp COCO is that children provide their own therapy. A child will see a friend at Camp COCO who has survived cancer, and he will say to himself, 'I can

be this person.'"

"Camp COCO gives children the opportunity to relate differently to their fellow patients, siblings, our medical team and even themselves," Dr. Loew continued. "I remember one girl who said that when she came to Camp COCO, everyone knew what she was going through – even the boys. This is the level of support and treatment that Camp COCO provides."

This year the camp had the feel of a university campus with activities that reflected the social life of a college. Campers participated in a pep rally, a homecoming celebration, a spring beach party, a skit night and a prom. The cabins were identified as sorority and fraternity houses.

"If you had attended our camp this summer, you would have been surprised at how enjoyable the whole experience can be," said Dr. Loew. "At Camp COCO, kids who have no hair because of cancer treatment are not unusual. At other camps, they would be looked on as oddities. The camp gives a normal, life-affirming setting to children facing severe health problems."

Camp COCO is privately funded. ■

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Celebrating MMR's 25th anniversary

This year marks the 25th anniversary of the combined measles, mumps and rubella vaccine. The following compares the number of annual U.S. cases in the year each part of the vaccine was approved with the number of annual U.S. cases last year.

	Annual cases
 Measles	
1963	385,156
1995	301
 Mumps	
1967	152,209
1995	840
 Rubella	
1969	57,686
1995	152

Source: U.S. Centers for Disease Control and Prevention

State allows physician discretion in timing of MMR2

IMMUNIZATION: Doctors may take steps to exempt patients from school entrance requirement. BY DAVE WIETHOP

[SPRINGFIELD] Illinois physicians have leeway in timing the second round of measles-mumps-rubella immunization they administer to children, according to the Illinois Department of Public Health's recent reinterpretation of the vaccine requirements in the state school code. MMR2 can be given at any age the physician believes is medically appropriate provided that at least one month has elapsed since administration of the first dose and that the exemption is approved by the school nurse or person responsible for compliance at the school, said Ralph March, IDPH immunization section chief.

Illinois, like many states, requires the first round of MMR when a child is 12 to 15 months old. The second round is generally given at age 5, coinciding with the child's entrance into kindergarten and with the administration of the diphtheria-pertussis-tetanus and oral polio vaccines. That timing allows schools to track more easily children's immunization records, but the age 5 requirement has been controversial.

Some physicians favor MMR2 immunization between ages 10 and 12, March said. "If you immunize early in life, there might be a chance for waning immunity at the other end of the spectrum. We've identified a lot of vaccine failures in that junior high age group, but that was some time ago. [Some] pediatricians in Illinois felt they should have the option to administer this vaccine at the junior high level."

The Illinois State Board of Education, however, requires the second round at age 5 unless children receive exemptions from their physician. The state has always allowed exemptions from any immunization based on medical contraindications or a family's objections on religious grounds.

IDPH is now working with the education board to alert all schools to the possibility of exemptions from the age 5 requirement for MMR2, March said. The state prohibits children from attending school if the immunization records are not up-to-date and unless state-approved exemptions are in place, he noted.

Physicians exercising the MMR2 exemption should write to the school nurse or the individual responsible for compliance at the school, March said. Then, if those school representatives "feel uncomfortable with something they think has not been interpreted by the state health department or state board of education, they send it to [IDPH]."

Stephen Saunders, MD, chief of IDPH's Division of Family Health, urged local health administrators not to view the exemption as a regression from the department's aggressive policy regarding a second dose of MMR. In a June 26 letter, he wrote that the exemption should

be considered as an alternative for patients with possible contraindications to an earlier second dose.

Although IDPH officials term the change little more than a reinterpretation of a long-held exemption option, that reinterpretation has regenerated interest in related issues. At the June 29 meeting of the ISMS Board of Trustees, physicians asked whether later administration of MMR2 could more effectively protect patients from later outbreaks – during college, for example. The Society's House of Delegates adopted a resolution in 1995 asking IDPH to recommend MMR3 immunizations if they were found to be

necessary. The ISMS Council on Medical Services reported at that Board meeting that it supported a state requirement of two MMR immunizations by school entrance and administration of MMR3 only if MMR2 was given out of sequence or if MMR vaccinations were given too close together. The council also reported that it believed the exemption addresses physician concerns related to the administration of MMR2 at school entrance.

"My concern was that if we give an MMR too soon, we may not have adequate protection later on," said William Kobler, MD, a Rockford family physician
(Continued on page 12)



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REPORT for Illinois Physicians

MEDICARE PART B

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- 83020 Hemoglobin; electrophoresis (eg, A2, S, C)
- 83912 Nuclear molecular diagnostics; nucleic acid probe with amplification, interpretation and report
- 84165 Protein; electrophoretic fractionation and quantitation
- 85390 Fibrinolysins or coagulopathy screen, interpretation and report
- 85576 Platelet; aggregation (in vitro), each agent
- 86255 Fluorescent antibody; screen, each antibody
- 86256 Fluorescent antibody; titer, each antibody
- 86320 Immuno-electrophoresis; serum
- 86325 Immuno-electrophoresis; other fluids (eg, urine, CSF) with concentration
- 86327 Immuno-electrophoresis; crossed (2-dimensional assay)
- 86334 Immunofixation electrophoresis
- 87164 Dark field examination, any source (eg, penile, vaginal, oral, skin); includes specimen collection
- 87207 Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (eg, malaria, kala azar, herpes)
- 89060 Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)

*CPT five-digit codes, two-digit numeric modifiers, and descriptions only are © 1996 American Medical Association.

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EDITORIAL

Beyond sound bites

In our sound-bite world, we get a lot of information, but we don't necessarily process it or understand it – a problem for physicians and the public as health care keeps changing. Consider a survey cited in the July 31 edition of the New York Times that showed only 43 percent of the 1,011 respondents said they had ever heard of the Kassebaum-Kennedy bill. The measure, of course, would reform health insurance and create a four-year medical savings account project, and it has been widely covered by the media. The bill had been passed by Congress and was expected to be signed by the president as this issue went to press. But despite the importance of those reforms – described by the president as “a long overdue victory for the millions of Americans who live in fear of losing their health insurance” – some Americans don't even know a battle was waged on their behalf.

The survey showed an even lower level of awareness of MSAs. In addition, only 27 percent of respondents said they understood the term “managed care,” which prompted an executive at the Kaiser Family Foundation to say, “There may be some enthusiasm [for managed care] among marketeers, but the public is living on another planet.”

Maybe the residents of that other planet need more complete information or need it placed in context or need it repeated more often. Yet the sound bites keep coming without regard for those

needs. The Pennsylvania Health Care Cost Containment Council, for example, recently issued a study of 40,000 heart attack hospitalizations, for the first time offering public comparisons of mortality rates by type of payer, by individual hospital and by physician, according to the July 29 issue of AM News. Physician groups with higher-than-expected death rates said they worried that such snapshots could alarm patients and hurt their practices.

A form of physician report card may soon go public in Massachusetts, according to the July 30 issue of the Wall Street Journal. The governor is expected to sign a bill that would give consumers easy access to data on every Massachusetts doctor's malpractice record, disciplinary actions by hospitals or medical boards, lawsuit settlements and convictions for felonies or serious misdemeanors. Consumers could get the data by calling a state-funded 800 number this year. Next year the information would be posted and updated daily on the Internet, as well as supplied on CD-ROM to public libraries. Will the public recognize certain realities, though? For instance, in Massachusetts, Ob/Gyns can expect to be sued twice every 10 years on average, while low-risk specialists like dermatologists are rarely sued, according to a Boston insurer.

Consumers need to understand the whole story on how and why physicians are ranked, sued and disciplined, not just get a passing glance at complex issues.

PRESIDENT'S LETTER

Illinois Medical PSO – opportunity is knocking

Sandra F. Olson, MD



The PSO will be owned by and run for the physicians of Illinois who choose to be involved.

The Illinois Medical Physician Services Organization is a new for-profit company that is dedicated to helping physicians develop and operate practice organizations capable of contracting with employers and insurers to manage patient care. It will be owned by and run for the physicians of Illinois who choose to be involved. Illinois physicians can invest in the PSO during the term of a pending offering of its securities. I plan to make that investment.

To fully understand why the PSO is so critical to Illinois physicians collectively and to you specifically, it may help to have some background. All physicians, no matter what their area of practice, are constantly bombarded with the recent, unprecedented explosion of new, sophisticated, scientific data they must master and assimilate into their knowledge base to practice state-of-the-art medicine. However, here doctors have an advantage. They spend years in medical school and residency developing a structure onto which the new information can be added and in which it can be used.

But increasingly, we are faced with another barrage of information we must incorporate into our professional lives that isn't so familiar to us and for which most of us are ill-prepared. Here I refer to the business side of our practices, hardly the focus of our education. This has become an increasingly possessive captor of our time and efforts that we must respond to just so that we can survive.

How on earth did we get to this state of affairs? As Medicare grew in the '60s and '70s, regulations started multiplying exponentially, and we saw the growth of government bureaucracy. But the managed care industry jumped on the bandwagon and spawned a family of red tape – called hassle – that makes the old Medicare regulations look tame. We are now required to be amateur lawyers, accountants, economists and social workers. The problem is, we are not prepared for or schooled in these disciplines, so we get constant on-the-job training with a few courses thrown in here and there. So much time has to be

dedicated to these efforts that we run the risk of becoming distracted from our primary work of treating patients. As a result, many physicians often express anger, frustration and hostility as they continuously feel a loss of control over their professional lives.

When many members were asked what they needed to help them cope with these external pressures, they responded overwhelmingly with the desire to have access to the expertise needed to run the administrative side of medical practice in an efficient and cost-effective structure, especially as it relates to the managed care environment. Hence, the PSO, which has been officially launched.

The PSO plans to have three basic service lines. First will be consulting and development, geared to help members develop physician-led strategies to compete in the managed care market, build physician-directed organizations and assess and negotiate managed care contracts. Second will be managed care operational services to help physician clients gain access to information systems and other services that will enable them to improve care and manage risk within budgeted systems such as capitation. Services that will fall under this category are credentialing, contract management, utilization management, quality improvement, claims processing and financial management. The third line will include practice management services such as billing, collections, personnel management and training.

The PSO plans to make these services available to all Illinois physicians, whether they are solo practitioners, are in small groups or are members of large clinics. Any and all of these services will be available singly or in varying combination for those who wish to utilize them. The general theme of this endeavor is to provide an infrastructure to practicing physicians so they can do what doctors do best – and that is to take care of patients. There is more specific and complete information on our PSO presented in this issue. I hope you find it interesting and stimulating.

GUEST EDITORIAL

Animal rights or human rights?

By Michael E. Carey, MD

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I was a neurosurgeon in Vietnam in 1968-69. Day and night, helicopters brought wounded soldiers to the hospital where our neurosurgical unit operated on more than 100 Americans with brain injuries each year. As young men died before my eyes, I began to wonder if we could have saved them if we had known more. I wondered, too, what would become of those who lived after they left our hospital with healing brains and spirits. Their faces wouldn't leave my memory.

So after returning, I followed up on all 93 survivors on whom our neurosurgical team had operated. Some came to the medical school where I am a faculty member. We assessed their brain function and general well-being, and I met with all of them and their wives. While many had some paralysis, amputations or partial blindness, I was relieved and inspired that most were able to do what they had planned before they entered military service. What a story of resiliency these veterans and their wives told.

I studied the literature and was amazed to discover that fewer than 25 laboratory research reports on brain wounds caused by bullets or shrapnel had ever been written worldwide, while there were thousands of experimental papers on stroke patients. Clearly almost nothing was known about brain wounding in modern biological terms to help people with such injuries. How could our government send young men and women off to wars without knowing the best way to treat brain wounds? Could we learn better ways to treat the more than 25,000 American civilians who get gunshot wounds of the brain each year?

To help solve this important problem, I received a contract from the Army to study the effects of a standardized small brain wound in anesthetized cats. My research team observed the physiological changes after the sudden disruption of brain tissue and blood vessels. This kind of research cannot be done in a computer model or on cells floating in a petri dish – it requires a living, breathing animal in order to find what treatments may lead to more complete recovery for living, breathing humans.

Soon the "animal rights" zealots stepped in – in a big way. They began bombarding my medical school and Congress with an international letter-writing campaign. Naively, I had thought most people could see through this tactic; I took comfort from a Gallup poll showing that 75 percent of Americans support the use of animals to advance medical science. But I was wrong.

An animal rights group printed false information claiming our research animals did not receive anesthesia. Of course we used anesthesia, because we did not want to inflict pain. Indeed, a panel of experts in brain research convened by the General Accounting Office wrote that my research was important and should continue. This panel found no evidence that animals suffered. Our cats – nobody's pets – were procured from licensed dealers. They were humanely handled in strict accordance with Department of Agriculture regulations, and their care conformed to the high standards of the American Association for the Advancement of Laboratory Animal Care. Members of Congress,

however, responded to animal activists' sensational, deceitful propaganda by cutting off the funding for my research.

Just after Congress closed our brain-wound laboratory, I was recalled as an Army Medical Corps officer for Operation Desert Storm. I returned to active duty in December 1990 at a forward field hospital in Saudi Arabia. It was clear that I would have to treat young Americans with brain wounds with no better techniques than those I used in Vietnam in 1969.

Mike Wallace and his staff at "60 Minutes" also wondered what happened to my research. Their investigation (first aired Jan. 24, 1993) showed how lies printed in magazines that appeal to pet owners get orchestrated into volumes of letters and calls to Congress from animal lovers. The politicians are cleverly manipulated by organizations such as People for the Ethical Treatment of Animals, which is adamantly against animal testing. Even

Even peer-reviewed, Defense Department-funded research projects on war injuries have been stopped.

Running a race against time

By Julie Full-Lopez

Copyright Julie Full-Lopez

Eleven years ago, I couldn't walk. This summer, I ran with the Olympic torch. What made the difference? Innovative medicines.

In 1981, I was 21, fresh out of college and ready to conquer the world when fate put a roadblock in my path: Doctors diagnosed that I had multiple sclerosis.

More than 200,000 Americans have MS. There is no known cause, and symptoms include weakness, tingling, numbness, lack of coordination, equilibrium disturbance, double vision, blindness and paralysis.

The majority of people with MS do not become severely disabled and continue to lead productive lives. Although a cure for MS has not been found, many symptoms can be relieved and controlled by drugs, and new treatments are being developed.

For the first five years after my MS was diagnosed, my symptoms were relatively mild. My knee would go numb, and I had bouts of double vision. But I kept active – having a child, teaching college, attending graduate school and playing all kinds of sports. But in 1985 I suffered an "acute exacerbation." My body simply went dead – I felt as if I was shot up with Novocain all over. I was 25 years old and looked and felt like an old woman who had just suffered a stroke.

After three months of therapy, I learned to walk again. Although I still was limping, I booked a trip to Aspen

and skied.

That "victory" made me even more determined to beat this illness. I started by learning all I could about available – and potential – medicines. I learned of a drug being tested in Israel and wrote asking to be included in the clinical trial. I was told I was too sick to treat. Another drug – really a cancer medicine – literally kept me going for nine years, until Betaseron was approved by the Food and Drug Administration.

This drug doesn't cure MS. But it decreases both the severity and the frequency of attacks. Thanks to this drug, I can work two jobs, pay taxes, raise my son and carry the Olympic torch. Without this medicine, there is no guarantee I would be here now.

The most important thing about Betaseron is that it opened the door to a cure. There are at least 10 medicines in testing for MS, and that gives me hope. But it takes nearly 15 years for a new drug to get from the laboratory to the pharmacy shelf. We need to speed up drug development so these new medicines can help the people who need them.

Fortunately, Congress is considering legislation that would help – through commonsense reforms of the way the FDA regulates drug development. This legislation would cut development times without cutting corners on safety.

Carrying the Olympic torch was a great privilege. But if I can help light the way to FDA reform, it will be like winning an Olympic medal. ■

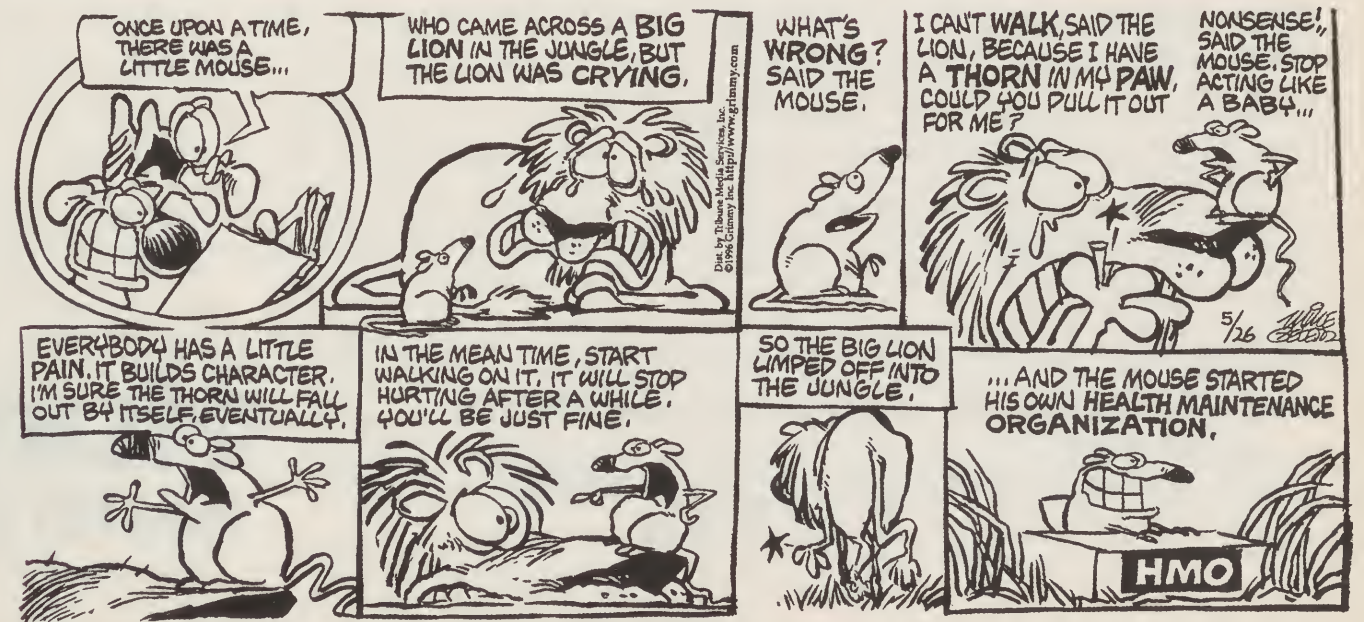
peer-reviewed, Defense Department-funded research projects on war injuries have been stopped by pressure on Congress and threats against researchers and their families – as happened to me and my wife, Betty Oseid, a pediatrician. The development of new antibiotics, vaccines, drugs for Alzheimer's and Parkinson's disease, and improved treatments for AIDS, diabetes, cancer and cardiovascular disease will stop if

appropriate animals cannot be used for research.

One wonders why such a small number of misguided people hold such power over politicians and opinion makers. Perhaps it's time for a majority of Americans to speak out in favor of biomedical research to save human lives and decrease human suffering. I wonder, does People for the Ethical Treatment of Humans have a good ring to it? ■

MOTHER GOOSE & GRIMM

BY MIKE PETERS



AMA approves tenets of Study of Federation

IMPLEMENTATION SET: ISMS-backed recommendations are among the provisions passed to expand membership.

BY WENDY ANDERSON

[CHICAGO] The basic provisions of the AMA Study of the Federation of Medicine, a project in the works for nearly four years, were approved during the AMA's Annual Meeting in June in Chicago. The goal of the project is to broaden representation and participation in the AMA to reflect changes in the medical profession's makeup and physicians' delivery of medical care, as well as to enhance professional unity. Provisions passed with the caveat that the changes will require ongoing refinements as implementation proceeds.

The Federation will comprise the AMA, plus state, county and specialty medical societies. As an indication of how closely linked the entities will be, the Report of Reference Committee I, which was approved, repeatedly refers to the AMA/Federation House of Delegates and AMA/Federation Board of Trustees.

The HOD voted to develop a "statement of collaborative intent" for the new Federation that, while respecting the autonomy of constituent organizations, also stresses trust and cooperation among all members to help the Federation speak with a unified voice and foster better communication and ultimately better patient care. It also will provide

for notice to Federation entities when a group within the Federation opposes policy positions established by the AMA/Federation HOD.

Provisions also call for greater outreach to doctors who are women, minorities and members of international medical groups, among others.

Passage of the study opens the door for a number of AMA delegate positions to be allocated to specialty societies in the AMA/Federation House of Delegates, starting with "balloting" in fall 1996 to determine the number of specialty society delegates and alternate delegates for the 1997 AMA annual and interim meetings.

Once a year, the AMA will send a specialty-representation "ballot" to each AMA member physician and fourth-year medical-student member, who will use the ballot to choose one specialty society as his or her representative in the AMA/Federation House of Delegates for the next year. For the first three years of implementation, the number of delegates and alternates allocated to a specialty society will be on a ratio of one delegate and one alternate for every 2,000 (or portion of 2,000) AMA members who select that particular specialty society. Starting in the fourth year the ratio will

become one for each 1,000 members. In addition, each specialty society that meets eligibility criteria and is represented in the AMA/Federation House will have at least one delegate and alternate regardless of the number of the AMA's approximately 300,000 members who select it.

Another provision approved requires member organizations to work toward the best interests of patients and physicians, share information on key public policy issues and work to find common ground on issues before they "agree to disagree." In addition, the AMA/Federation Board of Trustees will actively reach out to special-interest medical associations and mode-of-practice doctors and organizations as a means of gaining their involvement in the new Federation. Targeted would be groups with a particular ethnic, cultural, demographic, sexual, minority or other identity, and doctors in group or managed care organizations or who are solos, teachers, researchers, administrators or actively working in some other role.

As part of this effort to broaden its voice, the AMA HOD agreed to offer voting seats to the National Medical Association, the American Medical Women's Association and the American Osteopathic Association.

A new group, the Federation Coordination Team, will include 20 members who will clarify roles and coordinate efforts, and serve as advisers to the AMA Board, HOD and Federation. Team members will be appointed by a selection commit-

tee of five members appointed by Joseph T. Painter, MD, chairman of the Study of the Federation. Some team members will be drawn from members of the AMA Consortium Project Team, which has focused on improving collaborative relationships with national medical specialty societies, and from the AMA HOD. Others will be chosen to reflect the broad diversity of the Federation in terms of age, gender, career stage (including students and residents), and more. All team members are to be approved by the AMA Board.

During the coordination team's tenure, all Federation units represented in the HOD, as well as county medical societies, will be asked to provide financial support through annual contributions.

The life span of the team will be three years, assuming that the AMA/Federation Board of Trustees will take over the team's responsibilities at that time.

The Study of the Federation prompted reference committee and HOD discussion during the April ISMS Annual Meeting in Oak Brook. Some of the principles that delegates referred to the Illinois AMA delegation were that accommodation be made for all types of physician relationships regardless of specialty designation; that new groups granted delegate positions encourage participation of physicians by demographic, ethnic and cultural characteristics; and that larger specialty societies granted additional AMA delegates take a unified approach with the AMA on issues of mutual interest and concern. ■

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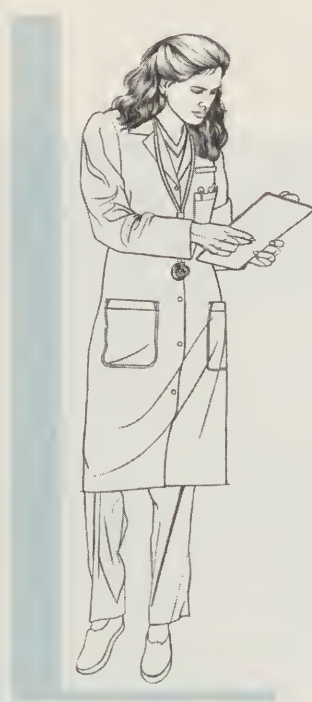
Self-assessments help physicians improve their practice operations and the quality of patient care.

BY KATHLEEN FURORE

Like your patients, your practice can benefit from an annual checkup, according to risk management experts. "There are a number of reasons I encourage physicians to engage in [office] self-assessments," said attorney Tim Nichols of Wildman, Harrold, Allen & Dixon in Chicago. "They can help physicians improve the quality of health care. They're a way of assuring that the equipment is in good working order. And they can assist in staff training and updating office procedures."

Self-assessments vary from practice to practice, but they should address certain basics – the physician's accessibility; documentation systems; follow-up procedures for missed appointments, lab reports, necessary tests and care, and referred patients; physician-patient and staff-patient communication; patient satisfaction; office equipment and physical facilities; scheduling procedures; and billing and collection procedures. Correcting glitches in those areas can prevent malpractice litigation in the future, the experts said. Nichols advised omitting patients' names when describing specific problems – as a safeguard against admissibility if a lawsuit is filed.

To illustrate the value of self-assessments, Nichols recalled a pediatric case: "A doctor recommended that parents bring their child to the emergency department, but he didn't record [that recommendation] in the chart. The parents didn't do it, and [after a bad outcome] they denied that the doctor ever said it. Especially in a case of 'he said, she said,' that is a vital piece of information and [potential] defense evidence in favor of the doctor, and it could be a critical factor in the jury's decision." An office self-assessment will quickly reveal whether a practice uses appropriate systems for recording medical advice given via phone, Nichols explained. "Good habits in those areas make cases



easier to defend."

Cases also are easier to defend if a physician can easily track and document lab reports and follow-up procedures, said attorney Dick Donohue of Chicago's Donohue, Brown, Mathewson & Smyth. "I can tell you that the disparity from physician's office to physician's office on follow-up on lab studies is shocking. Some have a tickler system, and some don't. Some call patients regardless of results, others only if there is a bad, unusual or abnormal report. And some have a nurse or clerical person put the results in a file, and the doctor never sees them. Things can really fall through the cracks."

A doctor, for example, might ask a patient to come back in three months for a follow-up breast exam after an abnormal mammogram. "But what if the patient doesn't come back [in three months], and when she finally does, she has rampant breast cancer?" Donohue asked. Physicians who fail to document their follow-up instructions create serious liability, he said, adding that office self-assessments can help doctors discover if and how those situations are being addressed.

Other situations may not seem as serious but can still be detrimental to the practice, said family physician Henry Martin-del-Campo, MD, a member of ISMIE's Family Practice, Ob/Gyn and Managed Care Risk Management subcommittees. "You may assume everything is running well. But what if you have a nurse who leaves at 3 p.m. every Friday and is telling patients, 'Nope, you can't see the doctor today.' And you're sitting there wondering why patients aren't coming in on Friday afternoons. That is an access to care issue and could have vast implications as far as risk management is concerned."

An office self-assessment could uncover such significant risk factors as improper storage of needles, prescription pads "laying all over" and billing systems that create problems for patients, said Dr. Martin-del-Campo. Physicians should go through their office with a critical eye, he added.

Managed care plan procedures also underscore the need for office self-assessments. As Dr. Martin-del-Campo noted, many managed care organizations routinely require participating practices to conduct such evaluations. "They want to make sure their patients have access to care when needed. If a sick child can't get in, that's a significant risk factor."

The referral requirements in managed care can create problems that can be remedied by office self-assessments, Donohue said. "A primary care doctor may say he or she wants the patient to see Dr. Smith. But either the patient doesn't go, or does go and Dr. Smith sends the results to the primary care doctor, and no one ever gets the results to the patient. Each assumes the other is taking care of it. I think that's something an assessment of procedures could have a positive effect on."

Practice profitability could also be at stake, Donohue noted. "Managed care plans may be coming in and saying, 'We

won't pay you or put you on our list because we're nervous about the way you're running your office. You may be real smart, but you have a lousy paper trail.'"

"Office self-assessments are important because they're a way of monitoring your own office to see how it measures up compared with national standards – to see if there are things that need to be improved," said Dr. Martin-del-Campo. "The main goal of self-assessments is quality patient care. Many doctors say they don't have time [to do assessments], but you should always have time for [processes that ensure] quality care."

ISMIE offers a questionnaire to guide doctors who are interested in conducting office self-assessments. To get a copy, call ISMIE at (312) 782-2749 or (800) 782-4767. In addition,

ISMIE offers risk management seminars and CME courses that provide tips on self-evaluations.

"Physicians can go to CME seminars devoted to improving the quality of communication and documentation," Nichols said. "They can measure what [the courses] are suggesting against what their office is doing. And there are a number of textbooks and brochures that offer good tips." Those tips should be put into practice in a self-assessment that is conducted once a year, no matter how successful or problem-free the office, he stressed. "Physicians should do assessments on a regular basis at the same time every year – not just after a problem occurs. They should have a meeting with the staff and check their equipment and their communication and documentation techniques." ■

Effective risk management for docs and staff is seminar topic

To be effective, risk management should be practiced by all participants in a medical practice – physicians, office managers, nurses, receptionists, business managers and other personnel. The ISMIE seminar "Risk Management: An Essential Office Practice" provides doctors and their staff with guidelines on how to develop and incorporate effective risk management office procedures. The sessions will be offered in several locations this fall.

Specific topics will include the significance of communication in preventing patient injury and litigation, documentation guidelines and the importance of documentation in defending against a lawsuit, guidelines for medical record access and retention, office procedures for patient follow-up, direction on managed care issues and billing and collection considerations.

The seminar will be presented at eight locations: Aug. 29 at the Holiday Inn Joliet in Joliet, Sept. 18 at the Riverwalk Restaurant in Geneva, Sept. 25 at the University Club in Chicago, Sept. 26 at the Keller-Ramada Inn in Effingham, Oct. 10 at the Holiday Inn City Centre in Peoria, Oct. 17 at the Springfield Hilton in Springfield, Nov. 6 at the Chicago Marriott O'Hare in Chicago and Nov. 7 at the Clock Tower Inn in Rockford. Registration and a continental breakfast will begin at 8:30 a.m., with the presentation from 9 a.m. to noon.

Cost is \$10. No telephone registrations are accepted, and attendees must preregister by mail to guarantee a seat. For information or to receive a brochure with a registration form, call the ISMIE risk management division at (312) 782-2749 or (800) 782-4767. ■

Trauma response time puts the squeeze on some physicians

Doctors discuss their concerns and the pros and cons of the state EMS system.

BY KAREN TITUS



John Berry

It took a coalition of 50 groups, including ISMS, five years to get the state's Emergency Medical Services Systems Act rewritten and signed into law last year. But the work isn't done yet: Rules have yet to be developed to implement the act's major overhaul of the EMS system – a considerable undertaking considering the range of the system's key players – physicians, hospitals, police and fire departments, and ambulance services. When it comes to physician involvement, a main concern is trauma response time. The state allows on-call trauma surgeons 30 minutes to get to a Level II trauma center from the time they're notified that a patient has been classified as Category I or as having life-threatening injuries. Notification is considered to have been given when the message is left for the doctor, not when the physician acknowledges the call.

If a Category II patient, with less severe injuries, becomes upgraded to Category I, the surgeon also has 30 minutes to respond, said Leslee Stein-Spencer, RN, chief of emergency medical services and highway safety at the Illinois Department of Public Health. The hospital with which the doctor is affiliated, not the doctor, can be sanctioned if the doctor fails to appear in 30 minutes. However, the hospital can issue a "warning" to the doctor.

While few would disagree that a critically injured patient should be under a trauma surgeon's care within 30 minutes, that's not always possible, said Richard Furman, MD, chief of surgery at Condell Medical Center in Libertyville. "Thirty minutes is ideal. But if you're hung up in a traffic jam or delayed by bad weather, there's not a lot you can do about it." Dr. Furman gave an example of a colleague who was delayed by traffic and called the hospital three times en route to inform those waiting. He received a warning about his tardiness anyway. "That's not right; that's not fair."

"Most of the physicians in this area are on staff at three or four hospitals," Dr. Furman explained. "That didn't used to be a problem because the hospitals are relatively close, maybe 10 miles apart. Unfortunately, the [population] growth has been so heavy up here that I can no longer get from one hospital to the next necessarily in under 45 minutes, just because of traffic patterns. And if that happens when I'm responding to a call, I've already committed a breach of state law, and I haven't even seen the patient yet. I could do everything right, yet I'm in trouble."

Downstate doctors – with two or three physicians typically covering an expansive geographic area – can have similar difficulties in getting to an emergency within 30 minutes if they are, say, an hour's drive from the trauma center when they get a call.

THE 30-MINUTE RULE also might create liability for physicians, Dr. Furman said. "If you're outside the standard of care, technically you've committed malpractice. You haven't necessarily, but you have technically, and the burden is on you to prove that you haven't."

Although hospitals volunteer to be designated as trauma centers, they generally mandate the participation of their medical staff surgeons but don't necessarily pay them for their participation. Some doctors contend that making surgeon participation voluntary would improve efficiency and care, attracting committed doctors who know they can meet time requirements.

In June, IDPH and ISMS' Council on Medical Services reviewed cases involving delayed response times and found that in the past two years, all cases in which sanctions were imposed involved flagrant violations of the 30-minute rule, such as two- or three-hour response times. Stein-Spencer said the state takes a hard look at patient outcome when it considers

sanctions. "If a patient has an untoward outcome based on a delay in response time, then we will look at taking action," she said. When a hospital recognizes a problem and takes its own action, she added, the department "will not take any action."

Following that review, the ISMS council recommended to the Society's Board of Trustees that no exceptions be made to the 30-minute rule for Category I patients. It reaffirmed a tiered response time based on the type of injury, which would give more response-time leeway to surgeons called for a Category II patient or one with less severe injuries. Although pros and cons were discussed at the June 29 Board meeting, ISMS remains "satisfied with the proposed draft rules [that] delineate different response time requirements based on the type of injury, but do not include leeway for Category I-designated patients," wrote Chairman of the Board of Trustees M. LeRoy Sprang, MD, in a July 3 letter to Kane County Medical Society President Eugene B. Loftin, MD.

For the tiered system to work effectively, hospitals have to carefully categorize patients, which may require changes in procedures and in field triage protocols for calling in trauma surgeons, Stein-Spencer

(Continued on page 10)

EMS-C generates issues, too

Working under a federal grant, Loyola University and IDPH are looking at ways to improve the EMS system for children. "Studies show what we are lacking – knowledge and skills," said Leslee Stein-Spencer, RN, chief of emergency medical services and highway safety at the Illinois Department of Public Health. So, improvements are focusing on pre-hospital care and the education of medical personnel. Grant money has already funded courses for physicians, nurses and emergency medical technicians, she said.

"There is some concern about the structure and regionalization of emergency medical services for children, and we want to ensure that the discussion and agreement are as wide as possible before we go ahead with the rules," said IDPH Director John Lumpkin, MD, referring to the rules that will be developed to implement the Emergency Medical Services Act.

At the urging of ISMS' Council on Medical Services, IDPH agreed to withdraw from proposed rules a recommendation for patient transfer protocols, including the transportation of children to an emergency department approved for pediatrics or a local pediatric center, neither of which is recognized in legislation. ISMS' position supports the concept of emergency medical services for children but does not support these particular

entities, which lack a statutory basis.

Likewise, the Illinois College of Emergency Physicians "is supportive of the concepts of EMS for children," but several issues need to be ironed out, including facility recognition, said Herb Sutherland, DO, director of emergency services at Central DuPage Hospital in Winfield. "What we need to figure out is how to handle the nuts and bolts when you get a kid with an emergency. Are we going to bypass certain hospitals, or are we going to try to increase the level of training at all hospitals, so that if you walk into any hospital emergency room you should be able to expect a certain level of treatment, training and background, and the availability of certain equipment?"

What those involved would like to do is avoid the competitiveness and confusion that might occur with the creation of Level I and II trauma centers for children, Dr. Sutherland said. "What we're trying to do is develop recommendations that would increase the educational and skill level requirements for physicians and nurses who staff every emergency department that wants to participate. What we don't want is having hospitals put together programs just so they can hang out a shingle that says, 'We are a pediatric center.'" ■

– Karen Titus

Trauma response

(Continued from page 9)

said. "A year ago a lot of Level II hospitals were not categorizing patients," she said. "The trauma surgeons were called in too often."

Herb Sutherland, DO, director of emergency services at Central DuPage Hospital in Winfield, agreed that improper categorization of patients – more than bad traffic or weather – causes problems with the 30-minute response time. "What needs to be focused on is what kinds of cases trauma surgeons are called in for," said Dr. Sutherland, a

member of the State Trauma Advisory Board. "If we can eliminate calling them in unnecessarily, I think there should be room to compromise."

"Overactivation" of the trauma system in certain regions has been a problem, said George Hevesy, MD, chairman of the EMS Committee for the Illinois College of Emergency Physicians and project medical director and vice president of the emergency department at St. Francis Medical Center in Peoria. Criteria set up when the act was overhauled a year ago didn't reflect the fine-tuning that comes with time, "so that if someone had one blood pressure that was

lower than normal, that would activate the trauma system," said Dr. Hevesy. "The surgeon would be called; he'd be coming in; and then they'd find out the patient was fine and [the surgeon's] services weren't needed."

"I think some people were getting burned out by this 'crying wolf' situation," Dr. Hevesy continued. "It was frustrating – you'd drop everything and come roaring in for this trauma, which wasn't nearly as bad as they billed it. It did cause some problems."

IDPH and the medical community have revised some of the guidelines used to categorize trauma patients, and some

hospitals have already implemented changes, Dr. Hevesy said. "It's now a win-win situation from the standpoint of patients getting the coverage they need and at the same time not activating the system when it's not needed."

"If there is room for improvement, certainly that may occur at individual hospitals," said IDPH Director John Lumpkin, MD. He said he believes it's better to let hospitals handle issues like classification of patients rather than requiring hospitals to follow mandates from state agencies. "It is an issue of quality control and quality of care at those hospitals. I don't believe that government needs to become enmeshed in those systems."

"The importance of assuring that there's a surgical presence in the hospital within a reasonable period of time – the 30 minutes – is a key component of the trauma system," Dr. Lumpkin added. "Remember, trauma center designation is a voluntary designation. We certainly feel that if a hospital holds itself out to be a trauma center, [it] ought to meet the guidelines."

TENSIONS COULD BE EASED by the addition of another trauma center tier, Level III, to handle the vast majority of trauma patients who are not seriously injured and do not require 30-minute response times, Dr. Furman suggested.

"The main reason [hospitals are] in the trauma system is either politics or publicity or both," Dr. Furman said. Adding a Level III category would allow some hospitals to participate more easily in the trauma system and publicize their participation; "the patient care would still be appropriate; and it would get the doctors out from under the gun," he added.

Before IDPH could take any such action, "we'd need some input from the medical community and from the hospital community that this is in fact the direction they want," Dr. Lumpkin said.

Regarding the issue of surgeon participation, hospitals should use voluntary on-call systems, said Aladin Mariano, MD, president of the medical staff at Alexian Brothers Medical Center in Elk Grove Village, which uses a voluntary system and pays surgeons for their services. "Level II centers should have committed physicians who can take care of Category I patients within 30 minutes," said Dr. Mariano. And that's exactly what a voluntary call system provides, he concluded. The Council on Medical Services will discuss the issue of voluntary call this month. ■

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Hospital appeals

(Continued from page 1)

unhappy with his employment situation that he decided to leave the hospital despite the restrictive covenant. He tendered his resignation in October 1995 and informed Rockford Memorial that Feb. 28, 1996, would be his last day – even though his contract required him to give the hospital six months' notice. He said he believed the hospital had violated the agreement, which meant he was not obligated to follow its resignation requirements. Dr. Holden then began telling his patients he intended to leave the Rockford area – something he expected to do until Feb. 5.

"It was a very busy day. I had one more patient to see and a big stack of messages to go through," Dr. Holden said. "At about 5 p.m., the vice president over my department came in and presented me with a letter imposing [the contract's] termination leave clause." That clause said Dr. Holden would receive his salary and full benefits until Feb. 28, but he could not practice out of his office or contact his patients. "Then the head of security escorted me out. I was told I'd have to set up an after-hours appointment to recover my things," he said. "For the next couple days I was not able to [reach anyone] to set up the appointment. When I finally did, they told me when I had to be there. When I got there, the office was just a mess, which just added fuel to the fire. I took my things, went home, contacted my attorney, and the rest is history."

"This is the ugliest scene of what the corporate practice of medicine can become and what I didn't want to allow to happen," Dr. Holden continued. "It all came down to control. The hospital wanted the power to call the shots, to tell doctors, 'This is how it's going to be, or you'll have to leave town.' I felt I owed it to my patients and other physicians to fight it – to put my foot down and not let [the hospital] get away with it."

THE TRIAL COURT RULED in Dr. Holden's favor "consistent with the Berlin decision," Haldeman said. In the Berlin case, the Circuit Court of Coles County in 1995 ruled Sarah Bush Lincoln Health Center's contract with general surgeon Richard Berlin Jr., MD, was unenforceable because the center is licensed as a not-for-profit corporation and cannot engage in medical practice. In April 1996 the Fourth District Appellate Court upheld the trial court ruling that such practice violates the Medical Practice Act, which states that only individuals licensed to practice medicine may do so.

The court in the Holden case "did not even get to the breach of contract issue," Haldeman noted. And Rockford Memorial would not comment on the breach of contract accusation. "That question is not relevant to the appeal, in that the appeal deals solely with the corporate practice of medicine question," King said.

Commenting on the contract provision at issue in the Holden case, Haldeman said: "It really was to protect the hospital from competition. And what's wrong with competition? You still could protect [hospitals] from the use of things like trade secrets. But in this case, it was blanket [protection]."

Grubb's decision, especially in tandem with the Berlin ruling, is significant for all Illinois physicians, Haldeman said.

"Hospitals and managed care people are grabbing all the authority they can get, and doctors are losing control of their professional lives. That makes it very difficult to practice medicine. The hospital is taking this on appeal to the second district hoping for a conflicting decision so the Supreme Court will have to take up the issue. But this decision and the Fourth District Appellate Court's decision are extremely important for independent practitioners around the state. They finally have the opportunity, if they desire, to set up a practice without having to make promises to the hospitals that now control many of the services."

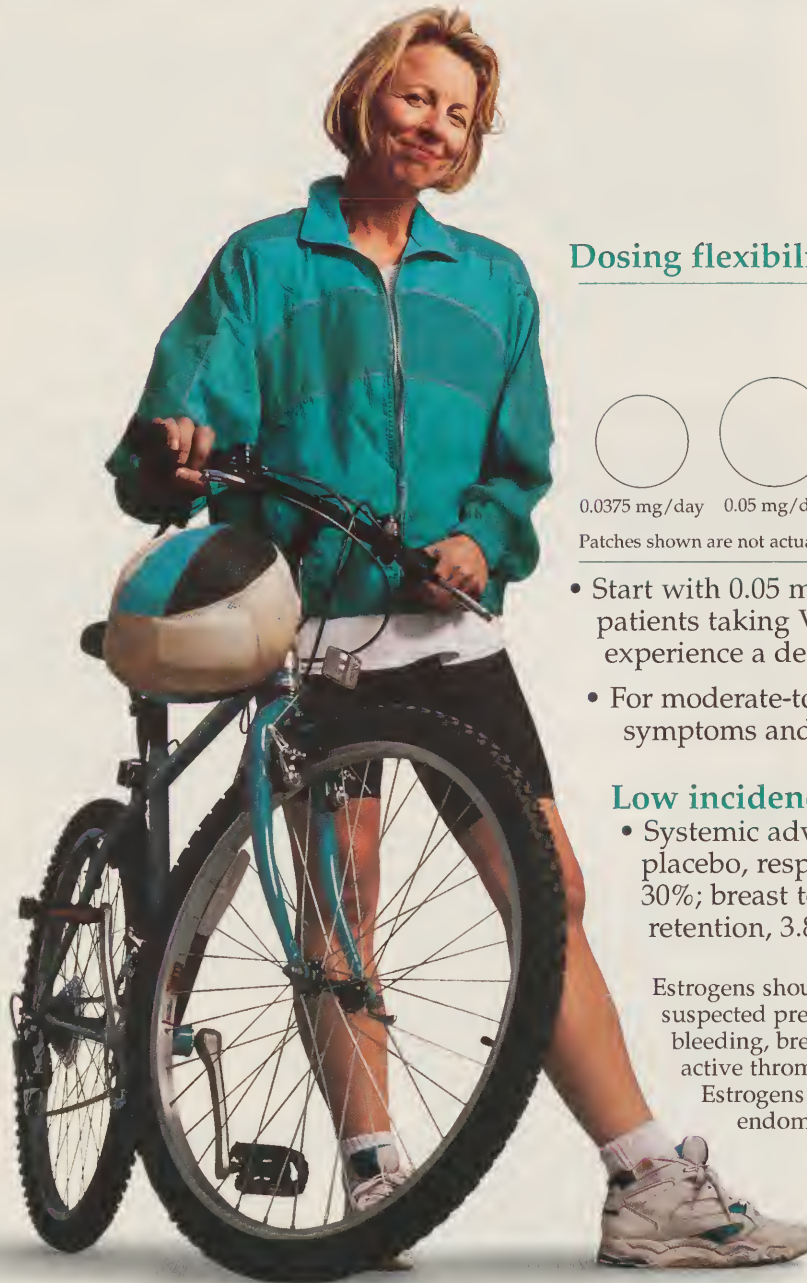
Courts in other districts, however, could still rule differently on the corporate practice of medicine, according to ISMS General Counsel Saul Morse. "We won't know the final outcome of this issue for physicians until the state Supreme Court makes a decision." Striking down an employment agreement, however, does not prohibit hospitals from entering into management services agreements with physicians for those physicians' practices, Morse explained. "There are alternatives that would give hospitals less control and require physicians to be more active in their practices."

ISMS policy states that if physicians

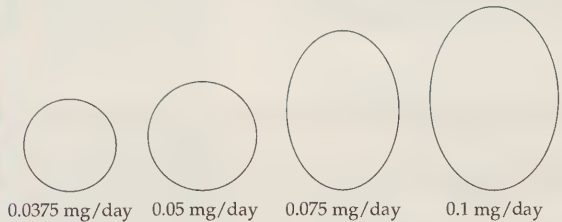
are employed by entities composed of people not licensed to practice medicine in all its branches, and if those entities bill for services, the care provided may not be in patients' best interests. Exceptions are those stated in the Medical Corporation Act, the Professional Service Corporation Act, the Health Maintenance Organization Act and the Voluntary Health Service Plan Act. Physicians practicing in training programs or as independent contractors are also exceptions.

Oral arguments in the Holden case are expected to begin in early 1997, Haldeman said. Illinois Medicine will report on developments. ■

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Estrogens should not be used in individuals with known or suspected pregnancy, undiagnosed abnormal genital bleeding, breast cancer, estrogen-dependent neoplasia, active thrombophlebitis, or thromboembolic disorders.

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Please see brief summary of Prescribing Information on next page.

Missouri Blues

(Continued from page 1)

insurer has more than 100,000 policies issued directly to its subscribers and will collect about \$90 million in premium revenues in 1996, making it one of the largest health services providers in Missouri, according to information from the insurer. Furthermore, the Blues said it has “incontrovertible documentary evidence” that it disclosed its plans for the MediGap policies “on at least seven separate occasions.”

“We played by the rules and adhered to all the laws, and we’re asking the court to tell Mr. Angoff to do the same,” said

Roy Heimburger, president and chief executive officer of Blue Cross and Blue Shield of Missouri and chairman and chief executive officer of RightCHOICE. “He approved the reorganization and the creation of RightCHOICE in April 1994. He did so in full possession of the facts. For nearly a year after his approval, [Angoff] said nothing to contradict his approval. Last year, he reversed course. He began demanding that we turn over hundreds of millions in assets belonging to our members.” The insurer filed suit to protect the assets of its 1.7 million members, Heimburger added.

The MDOI and the attorney general’s

office filed counterclaims in June asking, among other things, for the ability to seek relief up to and including the dissolution of Blue Cross and Blue Shield of Missouri. Hearings are expected to begin this month, according to MDOI spokesperson Randy McConnell. “We negotiated for roughly a full year in regard to Blue Cross and Blue Shield of Missouri’s public benefit actions and obligations. Unfortunately, they chose to litigate it. We had hoped to come to an amicable agreement. We believed we were close to settling it on May 13, and suddenly we were served with papers.”

Blue Cross companies in other states,

too, are grappling with how best to create for-profit entities and raise funds that will allow them to compete with managed care organizations. In what it called the largest health-related charitable donation in California history, Blue Cross of California on May 20 gave more than \$3 billion in assets to the two new independent charitable foundations it established to administer the endowment. The cash and stock came from the insurer’s conversion to for-profit status and the recapitalization of WellPoint Health Networks Inc., BCC’s principle subsidiary and one of the nation’s largest publicly traded managed care companies. It is the first time a health insurer converting to for-profit status has given the full market value of its holdings to charity, according to BCC information.

The foundations – the grant-giving California Endowment and the California Healthcare Foundation, which handles administrative functions – will work to expand access to affordable health care for underserved communities and individuals, said Leonard Schaeffer, chairman and chief executive officer of BCC and WellPoint.

As a result of the transaction, BCC’s public benefit activities and its commercial business will be completely separate. The independent foundations will assume the insurer’s public benefit role, while WellPoint – its for-profit affiliate – will assume BCC’s commercial business.

In spite of recent developments, the trend toward converting to for-profit status and creating foundations “has been overstated in the media,” according to Iris Shaffer, a spokesperson for the national Blue Cross and Blue Shield Association.

“In June of 1994, we started to allow our member plans to become for-profit at the parent level. But since then, only two have done that,” Shaffer noted. “One, Blue Cross of California, created the foundations. The other, Blue Cross and Blue Shield of Georgia, did not.” Georgia passed legislation allowing the insurer’s action, she noted.

“It is up to state regulators to decide,” Shaffer explained. “It’s totally directed by state laws, which can vary greatly.”

The Illinois Blues does not intend to copy BCC’s move. “We have no plans to issue common stock. There’s no need for it because we’re a mutual company – we’re owned by the policyholders,” said spokesperson Al Linburg. ■

State allows physician

(Continued from page 3)

and ISMS 12th District trustee. Data is inconclusive on the length of immunity for youngsters immunized at entry to kindergarten vs. those immunized at entry to middle school, he said.

In January 1995, the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians released a position that “the second dose of MMR is routinely recommended at 4-6 years or at 11-12 years but may be administered at any visit, provided at least one month has elapsed since receipt of the first dose.”

Illinois has a 98 percent compliance rate for MMR2, according to IDPH – at least partly due to a 1989 measles outbreak that killed 14 youngsters and stepped up compliance efforts, March said. In addition, the incidence of measles statewide has dropped from 5,000 cases in 1989 to only two in 1995, he added. ■

Vivelle™

estradiol transdermal system
Continuous delivery for twice-weekly application

BRIEF SUMMARY (FOR COMPLETE PRESCRIBING INFORMATION SEE PACKAGE INSERT)

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA IN POSTMENOPAUSAL WOMEN.
Close clinical surveillance of all women taking estrogens is important. Adequate diagnostic measures, including endometrial sampling when indicated, should be undertaken to rule out malignancy in all cases of undiagnosed persistent or recurring abnormal vaginal bleeding. There is no evidence that “natural” estrogens are more or less hazardous than “synthetic” estrogens at equiestrogenic doses.
2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.
Estrogen therapy during pregnancy is associated with an increased risk of congenital defects in the reproductive organs of the fetus, and possibly other birth defects. Studies of women who received diethylstilbestrol (DES) during pregnancy have shown that female offspring have an increased risk of vaginal adenosis, squamous cell dysplasia of the uterine cervix, and clear cell vaginal cancer later in life; male offspring have an increased risk of urogenital abnormalities and possibly testicular cancer later in life. The 1985 DES Task Force concluded that use of DES during pregnancy is associated with a subsequent increased risk of breast cancer in the mothers, although a causal relationship remains unproven and the observed level of excess risk is similar to that for a number of other breast cancer risk factors.
There is no indication for estrogen therapy during pregnancy or during the immediate postpartum period. Estrogens are ineffective for the prevention or treatment of threatened or habitual abortion. Estrogens are not indicated for the prevention of postpartum breast engorgement.

INDICATIONS AND USAGE

Vivelle™ (estradiol transdermal system) is indicated in the following:

1. Treatment of moderate-to-severe vasomotor symptoms associated with the menopause. There is no adequate evidence that estrogens are effective for nervous symptoms or depression that might occur during menopause and they should not be used to treat these conditions.
2. Treatment of vulval and vaginal atrophy.
3. Treatment of hyposteronism due to hypogonadism, castration, or primary ovarian failure.

CONTRAINDICATIONS

Patients with known hypersensitivity to any of the components of the therapeutic system should not use Vivelle.
Estrogens should not be used in individuals with any of the following conditions:
1. Known or suspected pregnancy (see Boxed Warning). Estrogen may cause fetal harm when administered to a pregnant woman.
2. Undiagnosed abnormal genital bleeding.
3. Known or suspected cancer of the breast.
4. Known or suspected estrogen-dependent neoplasia.
5. Active thrombophlebitis or thromboembolic disorders.

WARNINGS

1. Induction of Malignant Neoplasms. Some studies have suggested a possible increased incidence of breast cancer in those women taking estrogen therapy at higher doses or for prolonged periods of time. The majority of studies, however, have not shown an association with the usual doses used for estrogen replacement therapy. Women on this therapy should have regular breast examinations and should be instructed in breast self-examination. The reported endometrial cancer risk among unopposed estrogen users is about 2- to 12-fold greater than in nonusers and appears dependent on duration of treatment and on estrogen dose. Most studies show no significant increased risk associated with the use of estrogens for less than 1 year. The greatest risk appears associated with prolonged use with increased risks of 15- to 24-fold for 5 to 10 years or more. In three studies, persistence of risk was demonstrated for 8 to over 15 years after cessation of estrogen treatment. In one study, a significant decrease in the incidence of endometrial cancer occurred 6 months after estrogen withdrawal. Concurrent progestin therapy may offset this risk, but the overall health impact in postmenopausal women is not known (see PRECAUTIONS).
2. Gallbladder Disease. Two studies have reported a 2- to 4-fold increase in the risk of surgically confirmed gallbladder disease in postmenopausal women receiving oral estrogen replacement therapy, similar to the 2-fold increase previously noted in users of oral contraceptives.
3. Cardiovascular Disease. Large doses of estrogen (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown in a large prospective clinical trial in men to increase the risks of nonfatal myocardial infarction, pulmonary embolism, and thrombophlebitis. These risks cannot necessarily be extrapolated from men to women. However, to avoid the theoretical cardiovascular risk to women caused by high estrogen doses, the dose for estrogen replacement therapy should not exceed the lowest effective dose.
4. Elevated Blood Pressure. Occasional blood pressure increases during estrogen replacement therapy have been attributed to idiosyncratic reactions to estrogens. More often, blood pressure has remained the same or has dropped. Postmenopausal estrogen use does not increase the risk of stroke. Nonetheless, blood pressure should be monitored at regular intervals with estrogen use, especially if high doses are used. Ethinyl estradiol and conjugated estrogens have been shown to increase renin substrate. In contrast to these oral estrogens, transdermally administered estradiol does not affect renin substrate.
5. Hypercalcemia. Administration of estrogen may lead to severe hypercalcemia in patients with breast cancer and bone metastases. If this occurs, the drug should be stopped and appropriate measures taken to reduce the serum calcium level.

PRECAUTIONS

General

1. Addition of a Progestin. Studies of the addition of a progestin for 10 or more days of a cycle of estrogen administration have reported a lower incidence of endometrial hyperplasia than would be induced by estrogen treatment alone. Morphologic and biochemical studies of endometria suggest that 10 to 14 days of progestin are needed to provide maximal maturation of the endometrium and to reduce the likelihood of hyperplastic changes. There are, however, possible risks that may be associated with the use of progestins in estrogen replacement regimens. These include

- (1) adverse effects on lipoprotein metabolism (lowering HDL and raising LDL), which could diminish the purported cardioprotective effect of estrogen therapy (see PRECAUTIONS, below);
 - (2) impairment of glucose tolerance; and
 - (3) possible enhancement of mitotic activity in breast epithelial tissue, although few epidemiologic data are available to address this point (see PRECAUTIONS, below).
- The choice of progestin, its dose, and its regimen may be important in minimizing these adverse effects, but these issues will require further study before they are clarified.
- 2. Cardiovascular Risk.** A causal relationship between estrogen replacement therapy and reduction of cardiovascular disease in postmenopausal women has not been proven. Furthermore, the effect of added progestins on this putative benefit is not yet known.

In recent years, many published studies have suggested that there may be a cause-effect relationship between postmenopausal oral estrogen replacement therapy *without added progestins* and a decrease in cardiovascular disease in women. Although most of the observational studies which assessed this statistical association have reported a 20% to 50% reduction in coronary heart disease risk and associated mortality in estrogen takers, the following should be considered when interpreting these reports:
(1) Because only one of these studies was randomized and it was too small to yield statistically significant results, all relevant studies were subject to selection bias. Thus, the apparently reduced risk of coronary artery disease cannot be attributed with certainty to estrogen replacement therapy. It may instead have been caused by life-style and medical characteristics of the women studied with the result that healthier women were selected for estrogen therapy. In general, treated women were of higher socioeconomic and educational status, more slender, more physically active, more likely to have undergone surgical menopause, and less likely to have diabetes than the untreated women. Although some studies attempted to control for these selection factors, it is common for properly designed randomized trials to fail to confirm benefits suggested by less rigorous study designs. Thus, ongoing and future large-scale randomized trials may fail to confirm this apparent benefit.

(2) Current medical practice often includes the use of concomitant progestin therapy in women with intact uteri (see PRECAUTIONS and WARNINGS). While the effects of added progestins on the risk of ischemic heart disease are not known, all available progestins reverse at least some of the favorable effects of estrogens on HDL and LDL levels.
(3) While the effects of added progestins on the risk of breast cancer are also unknown, available epidemiologic evidence suggests that progestins do not reduce, and may enhance, the moderately increased breast cancer incidence that has been reported with prolonged estrogen replacement therapy (see WARNINGS, above).

Because relatively long-term use of estrogens by a woman with a uterus has been shown to induce endometrial cancer, physicians often recommend that women who are deemed candidates for hormone replacement should take progestins as well as estrogens. When considering prescribing concomitant estrogens and progestins for hormone replacement therapy, physicians and patients are advised to carefully weigh the potential benefits and risks of the added progestin. Large-scale randomized, placebo-controlled, prospective clinical trials are required to clarify these issues.
3. Physical Examination. A complete medical and family history should be taken prior to the initiation of any estrogen therapy. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than 1 year without reexamining the patient.
4. Hypercoagulability. Some studies have shown that women taking estrogen replacement therapy have hypercoagulability, primarily related to decreased antithrombin activity. This effect appears dose- and duration-dependent and is less pronounced than that associated with oral contraceptive use. Also, postmenopausal women tend to have increased coagulation parameters at baseline compared to premenopausal women. There is some suggestion that low-dose postmenopausal mestranol may increase the risk of thromboembolism, although the majority of studies (primarily of users of conjugated estrogens) report no such increase. There is insufficient information on hypercoagulability in women who have had previous thromboembolic disease.
5. Familial Hyperlipoproteinemia. Estrogen therapy may be associated with massive elevations of plasma triglycerides leading to pancreatitis and other complications in patients with familial defects of lipoprotein metabolism.
6. Fluid Retention. Because estrogens may cause some degree of fluid retention, conditions that might be exacerbated by this factor, such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation.
7. Uterine Bleeding and Mastodynia. Certain patients may develop undesirable manifestations of estrogenic stimulation, such as abnormal uterine bleeding and mastodynia.
8. Impaired Liver Function. Estrogens may be poorly metabolized in patients with impaired liver function and should be administered with caution.
Information for the Patient
See text of Patient Package Insert, which appears after the HOW SUPPLIED section.
Laboratory Tests
Estrogen administration should generally be guided by clinical response at the smallest dose, rather than laboratory monitoring, for relief of symptoms for those indications in which symptoms are observable.
Drug/Laboratory Test Interactions
Some of these drug/laboratory test interactions have been observed only with estrogen-progestin combinations (oral contraceptives):

1. Accelerated prothrombin time, partial thromboplastin time, and platelet aggregation time; increased platelet count; increased factors II, VII antigen, VIII antigen, VIII coagulant activity, IX, X, XII, VII-X complex, II-VII-X complex; and beta-thromboglobulin; decreased levels of anti-factor Xa and antithrombin III; decreased antithrombin III activity; increased levels of fibrinogen and fibrinogen activity; increased plasminogen antigen and activity.
2. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T₄ levels (by column or by radioimmunoassay) or T₃ levels by radioimmunoassay. T₃ resin uptake is decreased, reflecting the elevated TBG. Free T₄ and free T₃ concentrations are unaltered.
3. Other binding proteins may be elevated in serum, i.e., corticosteroid binding globulin (CBG), sex hormone-binding globulin (SHBG), leading to increased circulating corticosteroids and sex steroids respectively. Free or biologically active hormone concentrations are unchanged. Other plasma proteins may be increased (angiotensinogen/renin substrate, alpha-1-antitrypsin, ceruloplasmin).
4. Increased plasma HDL and HDL₂ subfraction concentrations, reduced LDL cholesterol concentration, increased triglycerides levels.
5. Impaired glucose tolerance.
6. Reduced response to metopropine test.
7. Reduced serum folate concentration.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term, continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, testis, and liver (see CONTRAINDICATIONS and WARNINGS).

Pregnancy Category X

Estrogens should not be used during pregnancy (see CONTRAINDICATIONS and Boxed Warning).

Nursing Mothers

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk. In addition, estrogen administration to nursing mothers has been shown to decrease the quantity and quality of the milk.

ADVERSE REACTIONS

See WARNINGS and Boxed Warning regarding the potential adverse effects on the fetus, the induction of malignant neoplasms, gallbladder disease, cardiovascular disease, elevated blood pressure, and hypercalcemia.

The most commonly reported systemic adverse event to the Vivelle system in controlled clinical trials was headache. This occurred in approximately 36% of patients treated with active systems and in 30% of patients treated with placebo. The most common topical adverse events in these trials were erythema and pruritus at the application site. Most cases were considered mild. Fewer than 5% of patients on active drug at the final visit of the study had reactions of greater than mild intensity. Rash was reported rarely in these trials. Two patients out of 356 were discontinued from the trials due to skin irritation/erythema.

The following additional adverse reactions have been reported with estrogen therapy:

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Physician-driven care

(Continued from page 1)

wrote. Kaiser Permanente, he noted, created the first group plan to include prepayment, group practice and substantial medical facilities on a large geographic scale. "The traditional world of solo fee-for-service doctors was shaken in the early 1940s by a number of events, not the least of which was Kaiser's new world venture in health care for the U.S. worker," Hendricks wrote.

Today, Kaiser Permanente consists of the Kaiser Foundation Health Plans, which handles administration; the Permanente Medical Groups, a multispecialty group of physicians who provide medical services to Kaiser Permanente members; and the Kaiser Foundation Hospitals, a nonprofit public benefit corporation, according to Kaiser information.

In spite of the growing number of managed care entities, old-timer Kaiser Permanente remains the largest HMO in the United States — thanks, in large part, to the organization's being integrated and physician-driven, said Treleven.

Key to its integration are Kaiser's method of compensating its member physicians, its comprehensive benefits package and its operating structure. Kaiser gets a capitated payment for a comprehensive package of services no matter where they're provided — in a hospital, a physician's office or a patient's home. "For five decades we have brought together medical care delivery, financing and organization into a cohesive whole,

solely for the benefit of those who entrust us with their health care," said David Lawrence, MD, chairman and chief executive officer of the Kaiser Health Plan and Kaiser Foundation Hospitals. "In a marketplace that otherwise is pitting health plans against providers, patients against doctors and purchasers against health care organizations, it is this single-minded purpose that defines us."

There are, of course, many other capitated HMOs that offer comprehensive benefit packages. But unlike Kaiser, they pay individual physicians, hospitals and home health agencies who likely aren't directly involved in planning and organizing patient care for a single organization, since they may be affiliated with many area groups and organizations. Consequently, physicians in those organizations are unable to determine the number of patients provided by their affiliations with the various HMOs and the needs of those patients, a Kaiser source said.

By putting physicians in control of clinical decision-making and patients at the center of all decisions, Kaiser Permanente has been able to develop programs that not only improve health care but also contain costs. Programs designed to prevent premature births, for example, have prevented one in four premature deliveries, ultimately reducing the number of days babies spent in neonatal intensive care by 25 percent and saving more than \$1 million annually in Kaiser's Washington, D.C., region alone. In addition, the Permanente Medical Groups do not offer incentives that encourage primary care gate-

keepers to limit referrals to specialists as some managed care entities do. Physician leaders in each region's medical group determine member physicians' base pay. In some cases, physicians receive limited incentives related to factors including the region's financial performance, patient satisfaction and overall care, the source said.

Managed care consultant David Schuh, managing partner of Deer Creek Associates in University Park, Ill., said that physician control has been one key to Kaiser's success. "Kaiser has turned all clinical responsibility and the funds for clinical care over to physician groups, and the physician groups manage that as they see most appropriate."

Kaiser's discharge policy for new mothers is "a prime example of our physicians deciding what they'll do," Treleven said. "The mother and baby are not discharged until the doctor signs the discharge papers. The default is they stay in bed. With some other plans, the default is to make the patients leave unless someone pleads their case."

That kind of physician-driven model is becoming increasingly popular in today's managed care marketplace, said Schuh, whose company specializes in starting up HMOs. "We're seeing more and more physicians and physician groups, rather than insurance companies and other organizations, wanting to start HMOs. And we think physicians are the most appropriate managers of care."

That philosophy is shared by ISMS. It is, in fact, the guiding principle on which the new Illinois Medical Physician Ser-

vices Organization Inc. was founded. "The PSO will let doctors maintain their clinical independence because it will be run by physicians for physicians," said Edward Fesco, MD, chairman of the Illinois Medical PSO Board of Directors. Illinois physicians now have the opportunity to invest in the independent, for-profit corporation, a physician-driven company that will offer physicians in solo or group practices support and services in negotiation and contracting, practice development, managed care operations, administrative and financial planning, and capital formation. The Illinois Medical PSO will be owned by physicians who invest in the company's preferred stock and by the Illinois State Medical Holding Co., a wholly owned subsidiary of ISMS, Dr. Fesco said.

To be eligible to buy stock, physicians must be Illinois residents who are either licensed to practice medicine in Illinois or who have voluntarily surrendered their license to practice. The purchase price is \$1,000 per share. A minimum investment of five shares of voting-participating preferred stock is required, and investors who make that minimum purchase can buy up to 10 additional shares of nonvoting-participating preferred stock. Successful capitalization is essential to the implementation of the organization, Dr. Fesco said.

"Physicians interested in looking at the future and seeing what's going on would be almost shortsighted not to want [to invest in] such an entity," said M. LeRoy Sprang, MD, a member of the Illinois Medical PSO's Board of Directors. ■

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Illinois Medicine

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Physician-patient accountability makes inroads in managed care

PAGE 7



Ron Ackerman

BEFORE RECEIVING her battery of preschool immunizations at the Springfield City Health Department, Amanda Jordan (center) looks warily at Barbara Senalik, RN (right) and holds on to her mother, Tammy Jordan. The immunization clinic was conducted in mid-August by the department.

OIG initiative targets teaching hospitals for compliance audits

REVIEW: Government launches project to review teaching physicians' compliance with Medicare rule on billing practices. BY KATHLEEN FURORE

[WASHINGTON] The Office of Inspector General of the U.S. Department of Health and Human Services recently announced a program to determine how physicians at teaching hospitals are complying with the Medicare rule affecting payment for physician services provided by residents and whether services are being coded appropriately. The OIG initiated the nationwide PATH project after

it detected billing problems in the University of Pennsylvania's clinical practice plan, according to Lew Morris, the OIG's assistant inspector general for litigation coordination.

"We uncovered a very significant billing error rate involving upcoding and teaching physicians' billing for what residents did [without the teaching physicians' supervision]," Morris explained. "We figured it was an issue elsewhere, and preliminary work we did in the Philadelphia area identified a problem." Some of the Pennsylvania physicians were also improperly upcoding the level of service provided in an attempt to maximize Medicare reimbursement, according to the OIG. As a result of the OIG's review of the University of Pennsylvania physicians, the federal government recovered more than \$30 million, including damages under the Federal Civil False Claims Act. Under the negotiated settlement, however, the responsible parties were not excluded from the Medicare program, which they could have been, the OIG noted.

New guidelines for teaching physicians' services, which took effect July 1, "require the presence of a teaching physician during the key portion of the performance of a service in which a resident is involved for which carrier payment will be sought by the teaching physician," according to the June Medicare B Bulletin for Illinois. In addition, those who bill for surgical, high-risk or other complex procedures "must be present during all critical portions of the procedure and

immediately available to furnish services during the entire service or procedure," the guidelines state. Although the guidelines don't require teaching physicians to be present "during the opening and closing of the surgical field," those physicians must attend the entire viewing for an endoscopy.

Previously, physicians in teaching settings had to meet specific conditions to be considered attending physicians and to charge the carrier for services involving care by residents. The main requirement was for "a single attending physician who personally examined the beneficiary within a reasonable time

(Continued on page 11)

Advocate purchases Dreyer Clinic

MERGER: Transaction will help physician-driven clinic grow and share support systems. BY KATHLEEN FURORE

[AURORA] The Dreyer Medical Clinic officially became part of Oak Brook-based Advocate Health Care when Advocate bought the clinic June 28. Dreyer's 104 physicians will serve area residents while extending Advocate's presence in the western suburbs, according to Thomas Stemper, MD, chairman of Dreyer's Board of Directors. "Advocate is willing to invest a significant amount of capital in the Dreyer operation so that the clinic can expand its delivery system and recruit new physicians," he said. "This is essential if we are to continue

meeting the medical needs of a rapidly growing population."

"Dreyer Medical Clinic supports Advocate's vision of serving the entire metropolitan Chicago community," said Michael Soper, MD, Advocate's executive vice president of physician integration. "The purpose of the purchase is not to feed patients into our hospitals but to care for people in all communities."

Dreyer has, in fact, been caring for people since 1922. That was when John Dreyer, MD, who was known to make house calls on his bicycle, opened a

two-member medical practice in Aurora, according to Dreyer information. From the start, the clinic was a physician-driven entity dedicated to providing patients with progressive but cost-effective medical services. And that remains its primary mission today, according to Dr. Stemper and John Potter, the clinic's president.

Dreyer's progressive approach to health care delivery is evidenced by the fact that it bought into the principles of managed care long before practices like capitation became

(Continued on page 2)

Illinois physicians may invest in Illinois Medical PSO

The Illinois Medical Physician Services Organization Inc. is a newly formed company dedicated to helping physicians develop and operate practice organizations capable of contracting with employers and insurers to manage patient care. It will be owned and directed by physicians, and its mission is to enable physicians to participate in managed care on their and their patients' terms.

To serve physicians, the PSO must be fully capitalized, and it is turning to physicians for that financial support. Stock can be purchased only by legal residents of Illinois who are licensed physicians or have voluntarily surren-

dered their license to practice medicine. The stock offering is scheduled to expire Oct. 19.

Illinois physicians may hear more about the Illinois Medical PSO and the investment opportunity by attending one of the following programs scheduled in conjunction with county medical society meetings around the state: Morgan-Scott CMS, Sept. 3; Effingham CMS, Sept. 4; St. Clair CMS, Sept. 5; Adams CMS, Sept. 16; Lake CMS, Sept. 16; Macoupin CMS, Sept. 17; Greene CMS and Jersey CMS, Sept. 18; and Marion CMS, Sept. 19. For more information, call (888) ISMS-PSO. ■

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Advocate purchases

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prevalent in the Illinois marketplace. The clinic signed its first capitated contract in 1979 and now serves a managed care population of 46,500. "I came to Dreyer in 1979, and one of my initial recommendations was that the physicians begin to get experience in managed care," Potter said. "I felt that physicians needed to get their feet wet in the business before pressures became extreme."

Before becoming an Advocate subsidiary, Dreyer was, under Illinois law, a medical service corporation. "That meant only physicians could own stock. It had to do with the corporate practice of medicine laws. And the Board of Directors was made up of practicing physicians," said Potter, who served as the board's lay administrator. Every physician made his or her own clinical decisions, while a quality improvement committee audited their practices. Through an incident-report system, problems identified by the

Illinois Medical PSO plans to offer support to physicians

Helping physicians achieve operational efficiency was part of the rationale behind the new, physician-driven Illinois Medical Physician Services Organization Inc., according to Edward Fesco, MD, chairman of the Illinois Medical PSO Board of Directors. The independent, for-profit corporation plans to offer physicians support and services in negotiation and contracting, practice development, managed care operations, administrative and financial planning, and capital formation. Most important, it will be run by physicians for physicians, Dr. Fesco said.

To invest, physicians must be Illinois residents who are either licensed to practice medicine in Illinois or who have voluntarily surrendered their license to practice. The purchase price is \$1,000 per share. A minimum investment of five shares of voting-participating preferred stock is required. The Illinois Medical PSO will be owned by the physicians who invest in the preferred stock and by the Illinois State Medical Holding Co., a wholly owned subsidiary of ISMS, Dr. Fesco said.

committee were documented and reviewed, Potter said. In addition, Dreyer owned Dreyer Health Plans, an insurance company that evolved from an HMO, according to Potter.

Things have changed, however, as a result of the Dreyer-Advocate agreement. For example, physician ownership ended, and a separate corporation, the Dreyer Medical Group Ltd., was created to employ physicians. The medical group signed a long-term affiliation agreement with Advocate-owned Dreyer Medical Clinic for all services needed to operate the medical group. In addition, the health plan was sold to Blue Cross and Blue Shield of Illinois, Potter said.

Although Potter said he expects physicians to continue to make clinical decisions and remain heavily involved in

the clinic's governance, he noted that they will relinquish some control. "There is now a shared management situation rather than the autonomous one physicians enjoyed in the past," Potter said. "Their method of compensation must be approved. And operating and capital budgets, strategic plans and major commitments of capital must be jointly approved. But physicians still have to agree [with all decisions]."

Marc Schlesinger, MD, chairman of Dreyer's department of internal medicine, said he is confident Dreyer's physician-focused philosophy will continue. "Our medical group board still has a significant number of powers, especially as to how we practice medicine. And we'll have an equal say on major business decisions."

Under the new agreement, physicians will have to pay a management fee to Advocate. "It's basically a tax on the doctors' income," Potter said. "I think this arrangement may be unique among integrated systems because of the management fee situation and the fact the physicians don't have guaranteed salaries. In many cases, when hospitals buy physicians' practices, they've guaranteed the physicians' salaries."

The new structure will allow Dreyer to become more efficient and achieve economies of scale it could not have achieved on its own, according to Potter. "Being part of a bigger system gives Dreyer the opportunity to take advantage of operational efficiencies through common support systems in such areas as computer technology, quality measures and group purchasing as well as residency training programs."

Update

ISMS President Sandra Olson, MD, has moved to a new e-mail address at ISMS' site on the World Wide Web. The Society's site is at <<http://www.isms.org>>. Dr. Olson can be reached at s_olson@isms.org.

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Flooding disrupts Joliet hospital

EMERGENCY: Record rainfalls and damage activate state and local agencies. BY JANE ZENTMYER

[JOLIET] During a torrential down-pour early in the morning on July 18, lightning struck the transformer for Silver Cross Hospital in Joliet, knocking out the hospital's main power supply and leaving it on backup power. The intercom system and the telephones were also dead. Then water in the basement, which eventually measured four feet, reached the backup generator. At 7:51 a.m. the hospital lost all power.

"The one exception to all of this was our emergency room area, which is quite a recent addition to the campus and had its own independent power supply," said Irving Rudman, MD, vice president of medical affairs for Silver Cross.

In the next several hours, that emergency department became a command center as hospital staff implemented the disaster management plan, Dr. Rudman said. The hospital was put on bypass, and the operating rooms were closed. Nursing crews worked with two patients who had been on respirators that required electricity, substituting older, nonelectric equipment. Dr. Rudman and a senior nurse did rounds and found that nurses were managing to get around in the dark by using flashlights. The nurses reported no serious problems in caring for patients, Dr. Rudman said.

Silver Cross was just one victim of July flooding. In a 24-hour period that began July 18, storms dumped 7.9 inches of rain in Lisle, 9 inches in Joliet, 9.8 inches in Burr Ridge and 11.4 inches in Naperville. Aurora's 16.9 inches missed the national record by only two inches. Attributed to the flooding was one death, an 84-year-old man from Will County who suffered a heart attack while recovering possessions from his flooded basement, according to the Illinois Emergency Management Agency.

Gov. Jim Edgar declared as disaster areas the following 15 counties: Boone, Cook, DeKalb, DuPage, Grundy, Kane, Kendall, Lake, LaSalle, Lee, McHenry, Ogle, Stevenson, Winnebago and Will. Only four of those – Boone, Lake, Lee and McHenry counties – were not declared federal disaster areas as well. The declaration of a state disaster area allows state agencies to coordinate with local agencies to provide services like immunizations. A federal disaster declaration provides funds for rebuilding and fixing infrastructure damage, said Rex Coble, deputy director of IEMA and state coordinator for the disaster.

DURING AND AFTER the flood, state and local officials have worked to help those in need, with the Illinois Department of Public Health acting primarily as an adviser to local health departments, which have done the nitty-gritty work, said Karen Grueter, IDPH spokesperson. IDPH said it would continue working with local health agencies to track any increase in flood-related diseases, such as those carried by mosquitoes that might breed in stagnant water after flooding.

Local officials implemented preventive measures along with the cleanup. DuPage County health officials, for example, gave 5,000 tetanus immunizations to flood victims who may have cut

themselves while wading through potentially contaminated water. "Typically, you really don't want to do an immunization clinic during the middle of a disaster because you don't want people walking around with sore arms when they're trying to lift couches out of the basement," said Leland Lewis, director of administration for the DuPage County

Health Department. "But it was something they needed then."

Although there was no noticeable sickness, the county sampled area water and advised homeowners to boil water for several weeks after the flooding because of well water contamination, said David McNutt, MD, executive director of the DuPage County Health Department.

As for Silver Cross, the hospital's power was returned after about two and one-half hours. "By noon we knew we were out of the woods, even though we knew we still had a lot of work to do," Dr. Rudman said. Water from a flooded parking lot had spilled into the hospital's

main level and reached the cafeteria and the medical records and physical therapy areas, according to a hospital spokesperson. The hospital's temperature and humidity level had risen, and many instruments had to be sterilized again.

By 4 p.m. on July 19 the hospital was taken off bypass, in large part because everyone pitched in to help with cleanup, Dr. Rudman said. "We noticed the same thing back some years ago with the tornado in Plainfield. We had a full staff ready to go home at 7 in the morning. Some employees had considerable problems at home, but if we asked them, they stayed at their post, and that was incredible." ■



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REPORT for Illinois Physicians

CHEST PAIN

OPTIMUM LENGTH OF STAY FOR RULE-OUT ACUTE MYOCARDIAL INFARCTION PATIENTS

The guideline, Diagnosing and Managing Unstable Angina.¹, from the Agency for Health Care Policy and Research does not give precise instructions on when patients should be discharged who have had acute Myocardial Infarction ruled-out. These guidelines do emphasize characteristics of low-risk patients, namely:

- absence of severe, prolonged or rest episodes of "anginal" pain
- absence of prior known Coronary Artery Disease ("CAD")
- ST depressions on EKG which are not significant (< 0.5 mm)

In these patients, probability of death or nonfatal MI is slim in short-term follow-up, implying the safety of noninvasive, possibly outpatient workup. High-risk patients are notable for anginal pain associated with:

- prolonged typical angina of greater than or = 20 minutes
- pulmonary edema
- new Mitral Regurgitation murmur
- hypotension
- pain associated with new significant ST or T-wave changes

In the experience of many primary physicians and cardiologists in the Chicago area, the majority of low-risk patients can be identified, evaluated and discharged within a 24-hour period. In one study of 512 patients presenting with chest pain, 83% were able to be safely discharged in one (1) day. This was accomplished without cardiac catheterization and the short term course of these patients was benign². The AHCPR guideline suggests that stable patients should undergo a stress test before discharge. It is anticipated that more hospitals will offer extended hours for stress testing to allow expeditious predischage evaluation of patients in whom there remains concern of significant CAD. However, in a percentage of low-risk chest pain patients, diagnoses other than CAD become evident during the period of observation including chest wall pain, pericarditis, zoster, pulmonary embolism, gastrointestinal causes of chest pain, etc., which would largely preclude the need for stress testing. Informal stress testing (i.e., having the patient ambulate under monitored conditions) may suffice in patients felt to be at very low risk after observation. Additionally, it has been shown to be safe to discharge low-risk chest pain patients after 12 to 24 hours of uneventful observation and to have them return for outpatient stress testing.

¹ AHCPR, Clinical Practice Guidelines, #10, Unstable Angina: Diagnosis & Management, May 1994, US Dept. Health & Human Services

² Gaspoz J-M, Lee TH, et.al. Outcome of patients who were admitted to a new short-stay unit to "Rule- out" myocardial infarction. Amer J Cardiol 1991; 68: 145-49

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EDITORIAL

Doing it ourselves

Humans have been confronting change forever it seems. As early as about 500 B.C., Heraclitus wrote, "Nothing endures but change." More than 2,000 years later, the author of "The Ascent of Man" wrote, "Among the multitude of animals, man is the only one who is not locked into his environment. His imagination, his reason, his emotional subtlety and toughness make it possible for him not to accept the environment but to change it."

Physicians need to change the health care environment by regaining control over it — now. We can work at it individually, which would be a slow, indeterminate process. Or we can do it collectively and expeditiously through the Illinois Medical Physician Services Organization Inc., a physician-driven company that will provide support and services to physicians in all practice settings. Who knows better what we physicians want and need than our colleagues? That's why the independent, for-profit corporation will be owned by physician investors in the company's preferred stock and the Illinois State Medical Holding Co., a wholly owned subsidiary of ISMS.

Simply put, the practice of medicine is based on our doing what's best for our patients. But we can keep doing that only if we're able to influence or make decisions ourselves. To assume positions of influence, we need resources like those the Illinois Medical PSO plans to offer. Its services will be customized to meet each

physician client's particular needs and will include support in negotiation, contracting, practice development, managed care operations, administrative and financial planning, and capital formation.

Physicians in other areas are already acting. In Baltimore, a management services organization led by physicians is providing doctors with "a way to maintain their independence while protecting their patient base," according to the May 28 issue of Medical Economics. The majority of stock in the MSO is owned by doctors, and the organization's chairman, a physician, said: "We doctors don't have to sell our souls to hospitals, investment bankers or national insurance companies. We can do this ourselves. We have to be willing to hire good administrative help. We have to spend some money and raise some capital."

The Illinois Medical PSO also needs capital to become a reality. To help physicians learn about the investment and the PSO in general, the following programs have been scheduled in conjunction with county medical society meetings: Morgan-Scott CMS, Sept. 3; Effingham CMS, Sept. 4; St. Clair CMS, Sept. 5; Adams CMS, Sept. 16; Lake CMS, Sept. 16; Macoupin CMS, Sept. 17; Greene CMS and Jersey CMS, Sept. 18; and Marion CMS, Sept. 19. For more information about the meetings, call (888) ISMS-PSO. Don't miss the chance to hear about how we doctors in Illinois, like those in Maryland, can "do it ourselves."

PRESIDENT'S LETTER

There is madness in the method — as in patents

Sandra F. Olson, MD



Patents should not hinder physicians from giving the best care or limit patients' access to the best techniques.

Patents for medical equipment and materials are nothing new, having been around almost as long as patents have been issued — 200 years or so — as guaranteed by our Constitution. Inventors of new instruments, drugs and technology have been rewarded for their ingenuity with royalties, which seems reasonable and fair. Those inventors have advanced our ability to help our patients in so many ways that we take it for granted. Did you ever stop to think of what went into the design of lasers, advanced computerized biological monitoring, precision tools for delicate cardiac and neurosurgery procedures, concise genetic testing, drugs, etc.?

But somehow and somewhere we have gone over the line. I refer now to Dr. Samuel Pallin's claim for developing "no stitch" cataract surgery, which he said he invented in 1990 and which led to the granting of a patent. Dr. Pallin tried to enforce his ability to charge royalties by suing surgeons at the Dartmouth Hitchcock Medical Center. Those surgeons, who used his frown-shaped cut, won their case in federal court. The judge banned the collection of royalties by declaring this suit invalid. The ophthalmologists cited pre-1990 literature that described "no stitch" incisions that were slightly different from the one Dr. Pallin developed.

Method patents were first granted in 1954, but few were awarded until recently when the numbers started to grow. They do cover a variety of standard medical and surgical procedures — for example, ultrasound used for determining the sex of a fetus, skin-grafting techniques, internal suturing and some pain treatments, to name a few.

The AMA Council on Ethical and Judicial Affairs declared it unethical for physicians to seek or enforce a method patent. Congress is now wrestling with this issue. Rep. Greg Ganske, MD, and Sen. Ron Wyden proposed banning them except for a durable device or drug. Sen. Bill Frist, MD, proposed making it illegal for anyone to sue a doctor over a method patent. The way out of the dilemma may

be to just ban the enforcement. Dr. Ganske now favors Dr. Frist's approach to such a ban.

Innovative methods in medicine should be open to use by other doctors, free of charge, according to Ross Rubin, AMA vice president of legislative affairs. Imagine a doctor faced with several different methods of treatment. If some of them carried royalties, how would that affect the choice of technique or procedure? For example, what if Dr. McBurney patented his "point" as a guide for an appendectomy incision? What if Drs. Whipple and Billroth patented their innovative surgical techniques and demanded payment each time they were used?

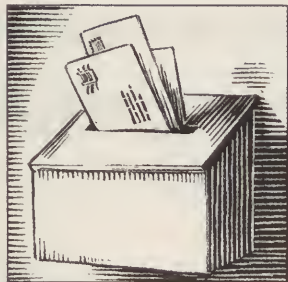
Patents should not hinder physicians from giving the best care or limit patients' access to the best techniques. Patents encourage innovation and reward those who use their talents to invent useful products and procedures, according to Donald Dunner, chairman of the American Bar Association's section of intellectual property law. Many see the aggressive enforcement of this trend as a sign of greed on the part of physicians. Dr. William Noonan thinks the real cause is the corporatization of medicine, a process that has made many doctors "increasingly aware and concerned about money." Doctors use this innovative ploy of obtaining method patents to bring them dollars, not academic advancement or peer applause. It was academia that spawned the biotech industry when the Supreme Court ruled in the early 1980s that novel life sources could be patented. Before that, every advancement was openly shared, and the pride of discovery and the resulting esteem of peers were considered the ultimate rewards. But times change. Let's hope that times don't change our efforts for the best care for our patients.

While on the subject of new technology, I should tell you that I've moved to a new e-mail address at ISMS' site on the World Wide Web. I look forward to hearing from you at s_olson@isms.org. Our Web site can be found at <http://www.isms.org>.

LETTERS

A legal paradox?

There is a paradox in the medical profession's fight for the \$500,000 cap on noneconomic damages and its fight against the damages to lives and health that result from HMOs' economic pressure on physicians to provide only skimpy medical care to patients. In the June 21 issue, a legislative recap and two editorials discuss hopes to overturn the May 22 ruling of Cook County Circuit Court Judge Kenneth Gillis, who declared the \$500,000 cap unconstitutional. A guest editorial in the same issue bemoans HMOs' financial windfalls from mergers and the big payoffs to their corporate players. This HMO drive for profits at the expense of patients rewards doctors for giving skimpy care and penalizes them for referring patients to specialists, emergency departments or hospitals. It also precludes some expensive medications, tests and treatments, and



forces physicians to sign gag orders to conceal from patients the possibility of treatments the HMO refuses to provide.

Although the guest editorial acknowledges that lawsuits are a weapon against HMOs that harm or endanger patients by undertreatment, it considers those suits "cumbersome, drawn-out, iffy" as a solution. Indeed, lawsuits against HMOs are ineffective at correcting the HMOs' ripoff of patients for financial gain because the suits come only after patients have already been injured or killed and because the current law renders lawsuits against HMOs totally useless as a deterrent.

The reason lawsuits have become so ineffective in deterring HMO abuses is clear from the legislative recap story, which reports on the 1985 tort reform legislation that abolished punitive damages in malpractice cases and ISMS' 1995 fight to win the \$500,000 cap on noneconomic damages. When the intentional deprivation of quality medical care injures or kills a child, a

disabled person or a senior citizen — who earned no income and therefore had no economic "value" — but costs an HMO only \$500,000, the risk factor to a multimillion-dollar HMO is small. With such a small risk, there is no incentive for an HMO to provide quality care to its thousands of patients and to cease the profit-generating and often negligent undertreatment of its patients.

This HMO "profits before patients" attitude would change quickly if an HMO risked million-dollar jury awards for every patient who was irreparably injured or killed, and multimillion-dollar awards in punitive damages for reckless, willful and wanton disregard for patients' health and welfare.

Physicians vigorously oppose punitive damages and uncapped jury awards that are directed at them, but they desperately need those same legal remedies to protect their patients from being abused and injured by HMOs.

— Theodore Shelly Ashbell, MD, JD
Chicago

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Brian Waring

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ISMIE Update

Handling consent issues involving minors

Attorneys advise physicians to use patient's best interest as guideline.

BY KATHLEEN FURORE

When a patient under 18 asks a physician for birth control or a test for pregnancy, drugs or HIV, how much are the parents entitled to know? And what should doctors do when parents ask them to administer such tests to an unknowing or unwilling minor? Those are questions with which many physicians struggle as they work to follow state statutes, maintain doctor-patient confidentiality and do what's best for their young patients, according to attorneys who deal with medical malpractice and confidentiality issues.

"These are the kinds of situations physicians deal with on a daily basis, and they can get real sticky," said Joan Lindauer, an attorney with Chicago-based Rooks, Pitts & Poust. Although the issue "has not popped up" in lawsuits she's handled, Lindauer said the issue evokes lively discussions in seminars.

Illinois law – specifically, the Consent by Minors to Medical Procedures Act – states that individuals under age 18 who are pregnant, married or parents can consent to a medical or surgical procedure performed by a licensed physician and are "deemed to have the same legal capacity to act and the same powers and obligations" as individuals of legal age. Procedures covered by this law include abortion, Lindauer noted.

The same statute says a parent or legal guardian's consent need not be obtained by physicians rendering emergency medical treatment or first aid "if, in the sole opinion of the physician, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor's health." In addition, an adult's consent is not required to provide medical care or counseling to under-18

victims of sexual assault or sexual abuse. Neither is it needed to authorize medical care or counseling related to the diagnosis or treatment of a minor's sexually transmitted disease, drug use or alcohol consumption or related to the effects of a family member's drug or alcohol abuse on the minor.

But there are gray areas in state law that require physicians to make tough judgment calls, according to attorneys. The Consent by Minors to Medical Procedures Act, for example, states that physicians involved in treating a child's STD or drug or alcohol problem should "upon the minor's consent, make reasonable efforts to involve the family" if they believe such involvement "will not be detrimental to the progress and care of the minor." It also states that physicians "may but shall not be obligated to" inform the minor's parent, parents or guardian about the recommended treatments. In addition if physicians counsel a child who abuses drugs or alcohol, or whose family member commits such abuse, they "shall not inform the parent, parents, guardian, or other responsible adult" about the child's problem or treatment without the minor's consent "unless that action is, in the person's judgment, necessary to protect the safety of the minor, a family member or another individual," according to the statute.

In addition, the Illinois Aids Confidentiality Act says that a physician who orders an HIV test for a minor patient who ultimately tests positive "shall make a reasonable effort to notify the minor's parent or legal guardian" if that provider thinks notification is best for the child. But the physician should have "first sought unsuccessfully to persuade the minor to notify the parent or legal guardian" or have "reason to believe that the minor has not made the notification," according to the act.



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Physicians who deal with issues related to consent of minors might use a "sliding scale" based on a patient's age and his or her ability to comprehend the issues involved and make decisions, said attorney Roger Clayton of Heyl, Royster, Voelker & Allen in Peoria. "If a child is under 12, the parent is entitled to know everything. Between age 12 and 16, both parties should be informed. And if the child is over 16, there is some thought that the physician may not want to involve the parent if the child does not want the parent to know." The same age scale would apply in situations in which a parent asks a doctor to perform a test without the minor's consent or knowledge, he added. "As a child gets older, we recognize the child's rights concerning his or her own body."

Clayton added that physicians are concerned about how to treat noncustodial parents. His advice: "By statute, noncustodial parents have to be treated the same as custodial parents." The exception would be if a divorce or custody order stipulates that one parent has the right to make treatment decisions, according to risk management specialists.

The bottom line is that the child, not the parent, is the patient, said attorney Mark Fedota of Chicago's Fedota & Rocca. "The physician does have to consider, first and fore-

most, what is in the best medical interest of the patient." For example, in the case of a 16-year-old pregnant unmarried girl, a physician should consider the importance of getting prenatal care for the girl and the baby above any social aspects of the pregnancy.

Education and counseling are key in most situations involving minors' consent, Fedota stressed. "Say Mom and Dad think their child might be HIV positive. They want the child tested so they can get him into therapy if he is HIV positive as quickly as possible. But the child, the patient, doesn't want the test. Do you strap the child down and take a blood sample? This is where the counseling aspects of the legislation are thought of as more important than the blood test. You have to try to get all parties thinking along the same lines."

Communicating with and educating young patients before problems arise can also help establish a positive physician-patient relationship, build confidence between the physician and the patient and ultimately help prevent some of the contentious situations physicians face in consent-by-minor situations, Fedota noted. "Each case has to be handled in the best interest of the patient and involve as many people with whom and in whom the child has confidence."

Seminar walks insureds through litigation

ISMIE policyholders who have been named as defendants in medical malpractice suits can benefit from the ISMIE seminar "Taking Control: Managing Your Malpractice Lawsuit," which will be offered at various locations this fall. The program covers the legal process, ISMIE's claims management process and emotional coping techniques.

Panelists will start the two-hour seminar by discussing the initial phases of a lawsuit, the defense team's role, the steps in discovery, confidentiality issues and the emotional impact of being named a defendant. The seminar will continue with presentations on ways in which physicians can be active in their defense, the immediate effects of litigation on doctors and factors in deciding

whether to settle or defend a case. The concluding discussion will cover the trial experience and the long-term effects of lawsuits on physicians and their practices.

The seminars will be held on Sept. 18 at the Collinsville Holiday Inn in Collinsville, Oct. 16 at the Oak Brook Marriott in Oak Brook and Nov. 6 at the Clock Tower Inn in Rockford. Each begins with registration and refreshments at 5:30 p.m., followed by the seminar from 6 to 8 p.m. ISMIE-insured physicians and their spouses may attend for free.

For more information or to receive a brochure with a registration form, call ISMIE's risk management division at (312) 782-2749 or (800) 782-4767. ■

Physician-patient accountability makes inroads in managed care

A large employer coalition in Minnesota relies on physician governance and educated consumers.

BY RICK ASA

Direct contracting for employee health care – that is, employers' striking a deal with the care providers themselves – has quietly made inroads in some states during the past few years. But a new direct contracting plan in the Minneapolis-St. Paul area is making far more noise because of the corporate clout behind it. The nationally known employer coalition, the Buyers Health Care Action Group, counts among its 22 members such business heavyweights as 3M, American Express Financial Corp., General Mills, Honeywell and Dayton Hudson Corp.

During open enrollment this fall, some 400,000 of the businesses' employees, retirees and employee dependents will choose their health care from among 15 new, competing health care provider systems that made the cut after the BHCAG's request for proposals earlier this year, according to Steven Wetzell, BHCAG executive director. The systems run the gamut from the huge Mayo Clinic health system to two medical groups in a joint venture with 50 doctors. The systems' contracts will be effective Jan. 1.

Patients' choices will be based on three criteria: quality, cost and the specific services provided, Wetzell explained. BHCAG offers a standard benefit package to all employees but allows them to choose a provider system that is in a high-, medium- or low-cost tier. Based on the system and tier chosen, patients might make additional monthly contributions through payroll deductions.

BHCAG considers the model to be consumer focused because patients can switch systems and providers any time they want as long as the cost is equal or lower. To upgrade to a higher-cost provider, they must wait until the following plan year when the systems rebid. In addition, BHCAG provides descriptive information on each care system and its providers, comparative information on clinical measures of technical quality and patient-reported measures of quality, and comparisons of patient service and satisfaction among the care systems, according to BHCAG information.

The provider systems' competition for profit, in theory, depends on each care system's efficiency, service and quality, not on what is covered or not covered. In that respect, the new model is a traditional point-of-service arrangement, with a 70-30 out-of-network co-insurance premium and a limit on out-of-pocket expenditures.

Each care system bid a "claim target" on a per-



member, per-month basis, Wetzell explained. The targets in the provider proposals for each system assumed a standard benefit set and the entire population of BHCAG employees as a control, with an allowable risk adjustment based on which employees will actually select each care system. Fee schedules will float based on how each provider-sponsored organization performs relative to the claim target quoted, and the group will adjust fee schedules accordingly every quarter. If a system's utilization doesn't match its claim targets, its fees will go up or down every three months.

In its infancy, the new model has exceeded the BHCAG's initial expectations, Wetzell said. About 90 to 95 percent of all Twin Cities physicians belong to the plan, and despite the fact that the care systems' bids were sealed rather than negotiated, the bids were competitive and lower than expected. "We're doubling the number of doctors we're offering to our beneficiaries, and we're lowering our rates – and we did that without even negotiating," Wetzell said.

Minnesota may be unique, however, according to Carol O'Brien, senior attorney for the AMA health law division, who tracks direct contracting nationally. "They had three HMOs that already controlled the market; virtually every physician was in at least one of them; and there was virtually no price competition. They already had one of the most advanced managed

(Continued on page 8)

Physician-patient

(Continued from page 7)

care delivery systems in the United States."

Members of the Minnesota Medical Association are, in general, viewing the BHCAG model with "cautious interest," according to Patty Franklin, director of legal affairs for the MMA. She added that the association has not taken a formal position on the BHCAG model. "To the extent that this provides a viable option for another route of access to patients to provide health care, there is cautious optimism."

Although the new model's impact on physicians remains to be seen, it provides PHOs and other physician networks with a second chance to find a niche in a market that was essentially closed to them in the past, said Allan Baumgarten, a consultant on health care policy who writes annual reports analyzing key trends in the Minnesota health care market.

The HMOs that had saturated the market thumbed their noses at contracting directly with existing physician networks because they didn't need to, Baumgarten said. Three health care plans have controlled 78 percent of the managed care enrollment in Minnesota, he added,

and the new BHCAG model will challenge their dominant market share.

Some primary care physicians are concerned about one aspect of BHCAG, according to Tim Crimmins, MD, chairman of the MMA's Board of Trustees. Under the model, they can be part of several care system bids, but eventually they will have to choose one system, which BHCAG said it believes will build their accountability. Wetzell said that although the group understands the limitation is a "tough issue" for physicians, they "can't have their cake and eat it, too." Dr. Crimmins said primary care doctors should be able to belong to as

many or as few care systems as they see fit: "If a physician decides to align himself with one care system, fine."

"They want to sign with everybody, but that would be the old paradigm used to simply increase their volume," Wetzell said. "That's not committing to a specific process, developing protocols or taking a hard look at what specialists they want to refer to and establishing real partnerships with them. This forces them to make a decision and a commitment. What we're doing is inviting doctors to step to the plate and control their own destiny, but it does involve more accountability and taking on some things they haven't dealt with historically. The trade-off is that we get some insurers off their backs."

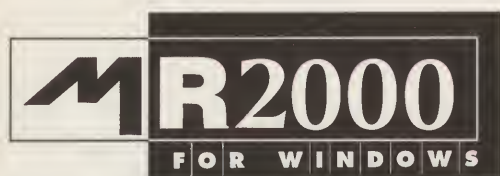
The BHCAG is also sensitive to putting the physician in the role of cost-benefit manager because "anytime you have the patient advocate looking at cost, patients are going to be nervous about that," Wetzell said. "But our view is that if anyone is going to make the tough decisions, who do you want making them, an insurance company or a patient advocate? If we don't push this to doctors, they are going to end up with more regulation and legislation taking those decisions away from them."

Wetzell noted that patients will be accountable, too. To make sound, cost-effective choices, they will need to be educated consumers. In focus groups, consumers said they were willing to try such a system if given a chance. "We're giving consumer groups the information they need and a premium allowance and turning it over to them and the doctors," Wetzell said.

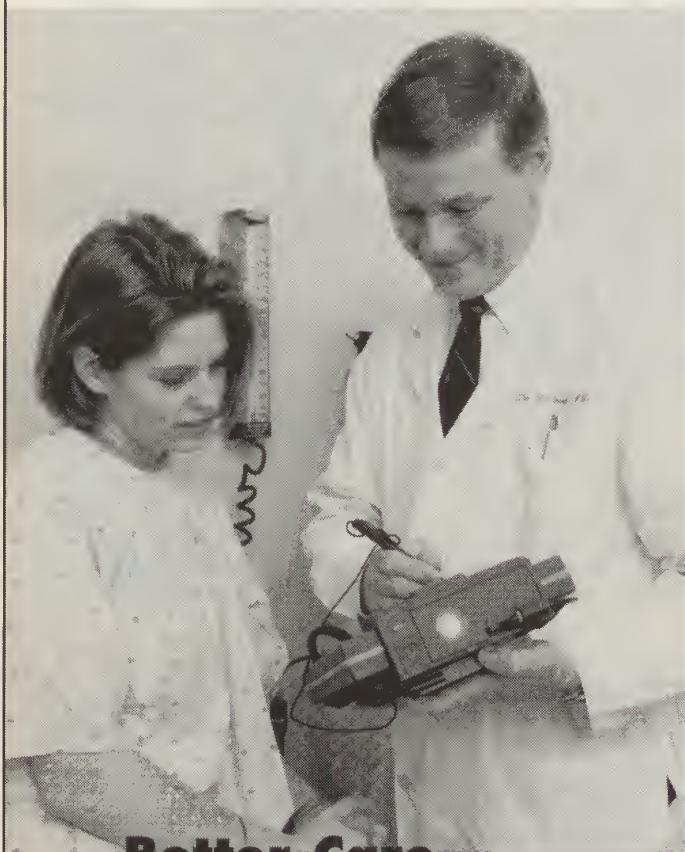
The businesses purchasing care through BHCAG have arrived at a standard of about \$100 to contribute to employees every month, which is the premium allowance, Baumgarten said. The employers may contribute more if they wish. For example, if many employees in a company choose the middle tier, the company may decide to cover that cost entirely for a period of time. Or they may stick to the lower coverage so that employees would contribute the difference.

The model differs from PHOs and independent service networks in some fundamental ways. BHCAG bears the insurance risk because it floats fee schedules. "If there's a bunch of heart attacks or whatever, the employers will take the hit for that, not the providers," Wetzell said. In addition, BHCAG adjusts risk among the care systems, and the care systems don't have to deal with third-party administrators or deal with solvency requirements, because BHCAG also bears that risk.

Franklin said the state medical association sees an important role for existing PHOs in terms of physician direction and governance of the care systems. Wetzell agreed: "Our bias is that there [should be] a lot of physician governance in the care system. We believe that's the best way to create a system that will work. We're not telling them how to structure their boards. We would be micromanaging if we said, 'This is how you have to govern yourselves,' although we are monitoring their structure. We had a couple of proposals that looked like traditional PPO or HMO products, and we didn't accept them because they didn't have enough physician involvement and the result didn't look like a care system."



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(Continued from page 1)

after admission, confirmed the diagnosis and course of treatment and was continuously involved in the care of the beneficiary throughout the stay," according to the bulletin. The OIG, however, believes the new guidelines "just clarify and strengthen the old guidelines," said an OIG source.

Teaching physicians must provide documentation to prove compliance with the new guidelines, according to the Carrier Manual Instructions on Medicare's Final Rule for Teaching Physicians. According to the rule, such documentation "may either be in writing or via a dictated note." For example, for initial hospital care, emergency department visits, new patient office visits and office and hospital consultations, the documentation "may be brief, summary comments that tie into the resident's entry and that confirm or revise [certain] key elements." Those elements are defined as "relevant history of present illness and prior diagnostic tests; major findings of the physical examination; assessment, clinical impression or diagnosis; and plan of care," the rule said.

"It is extremely important that all physicians engaged in teaching programs read the instructions very carefully and comply, with an emphasis on the documentation requirements as well as the [requirement for] presence during key portions of the exam," said Douglas Busby, MD, medical director of Medicare for Blue Cross & Blue Shield of Illinois. "The whole core is documentation. Don't bill if you're not there and doing [the procedure or exam] or if you're not [there] supervising it."

An exception to the physician presence requirement, however, will be made for certain low- and mid-level evaluation and management services furnished at primary care centers when specific conditions are met, Dr. Busby noted. The June Medicare B Bulletin for Illinois states that the services "must be furnished in a center that may be located in a hospital outpatient department or in a freestanding setting in which the time spent by residents on patient care activities is included in determining intermediary payments to a hospital." In addition, the patients must be "an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians."

For a complete list of requirements, physicians should refer to the bulletin or to HCFA's Carrier Manual Instructions. The programs most likely to qualify for the exception include family practice, general internal medicine, geriatric medicine, pediatrics and Ob/Gyn, according to the manual. Teaching institutions that qualify for the exception must submit a letter to their Medicare carrier. In Illinois, they should send the letter to Dr. Busby, 233 N. Michigan Avenue, 28th floor, Chicago, IL 60601.

Physicians can either wait for the OIG to initiate the review or do a self-audit, Morris said. Those who choose to participate actively in the process may reduce their liability but should contact the OIG to ensure they meet the requirements, according to an OIG source. "Active participation includes arrangement, at the party's expense, for an independent review conducted by a third

party using the OIG's review protocol," according to an OIG document.

All physicians in teaching roles – not just those in medical school settings – must comply with the program. "Right now we're focusing on the medical school level, but others will be included. We don't have a definite timetable, but we plan to reach everyone," the OIG source said.

The OIG will initially audit medical charts from 1994 but may select more recent charts as more complete recent data becomes available. If the OIG finds problems, it will forward audit information to the Department of Justice.

Because of the six-year statute of limitations, the DOJ will use the information from the audited year to determine the error rate for charts from 1990-1995 and to negotiate a settlement, according to the OIG.

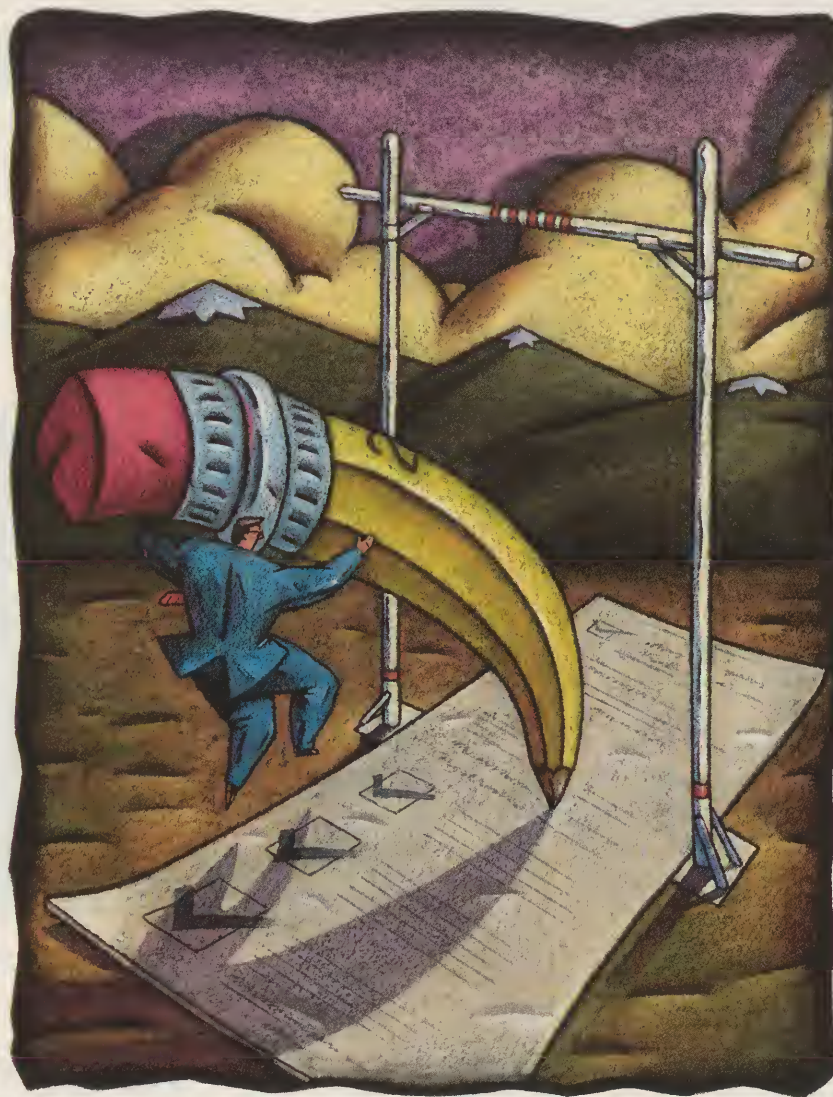
Concerns about the PATH program have been expressed by the Association of American Medical Colleges. "We think it needs a lot more definition at this point. There are still a lot of questions," said AAMC regulatory counsel Ivy Baer. The OIG, for example, has not identified the standards it will use when conducting the audits, according to Baer. She also said the AAMC is concerned that the

OIG is not working in tandem with the Department of Justice on the PATH initiative. "Right now, the OIG conducts the audits, comes up with results, and the local U.S. attorney's office negotiates a settlement. But the OIG can't say what the result of the audit will be."

Before participating in any PATH reviews, physicians should seek legal counsel regarding compliance with federal requirements for teaching physicians, advised ISMS' Legal Services Division.

Physicians who want to actively participate in the PATH reviews may contact Eileen Bechkes at the OIG, (410) 786-7104. ■

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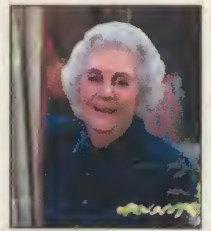
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HCFA delays HMO incentive deadline

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • SEPTEMBER 13 1996



*When is a
nursing home the
right choice?*

PAGE 9

Statewide meetings focus on Illinois Medical PSO

PROGRAMS: Presentation discusses need for physician leadership in managed care. BY KATHLEEN FURORE

[CHICAGO] Representatives of the Illinois Medical Physician Services Organization Inc. are traveling around the state this fall to discuss why Illinois physicians should lead managed care organizations and how the PSO can help them do so. The organization kicked off the meetings in mid-July, and they are scheduled through Oct. 15.

ISMS President-elect Jane Jackman, MD, spoke at the July 23 meeting in Springfield about why physicians need to change: "The future of physicians' leadership in medical care is threatened by insurance-driven managed care programs. If we want to continue to shape advances in medical care and continue to enjoy professional independence, meet patients' needs and expectations, control our own future and make our own clinical decisions, we must change the way we work." She explained that to preserve physician leadership,



Dr. Jackman

doctors "must be more proactive and set up managed care organizations. Physicians must reassert their leadership in the management of patient care and redirect managed care."

Dr. Jackman discussed the trend toward financial officers calling the shots in business and increasingly in medicine – a significant change from the environment she expected when she was in medical school. "But we can beat the financial analysts at their own game by becoming the masters of our own clinical and financial information," she said.

Support for achieving clinical and financial mastery, Dr. Jackman continued, will be available through the Illinois Medical PSO, a corporation "designed to help physicians who choose to participate in managed care to do so successfully." It will be owned by physicians who invest in the company's preferred stock and by the Illinois State Medical Holding Co., a wholly owned subsidiary of ISMS.

The organization "will provide consulting and development

services to physicians who are ready to learn more about their markets and their options," Dr. Jackman said. Those services will be targeted at all Illinois physicians, whether they practice as individuals or in large groups, IPAs, PHOs or other physician organizations. The services offered will help doctors negotiate managed care contracts, assume financial risk and achieve a meaningful financial return, she added. "When the PSO is fully capitalized and operational, it will offer information management systems to physicians, helping them link clinical outcomes with their use of resources."

The Illinois Medical PSO will be capitalized through a stock offering to physicians. To qualify, physicians must be Illinoisians. (Continued on page 14)

INSIDE

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officials identify
inappropriate use
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HCFA proposes new Medicare fee schedule

IMPACT: Family practice and internal medicine would fare best under RVU changes.

BY KATHLEEN FURORE

[WASHINGTON] The U.S. Health Care Financing Administration last spring published a proposed rule regarding changes to work relative value units that affect Medicare payments for physician services. The Social Security Act requires those payments to be based on national uniform RVUs that are based on the resources used in providing a service. The new RVUs will be effective for services furnished beginning Jan. 1, 1997, according to an ISMS analyst.

HCFA established the new RVUs after completing a five-year review during which it solicited public comments on (Continued on page 15)

SwedishAmerican poison control center closes

PUBLIC HEALTH: Rush-Presbyterian-St. Luke's has the only remaining center in the state. BY JANE ZENTMYER

[ROCKFORD] Another of Illinois' poison control centers has lost its fight to stay open because of a lack of consistent funding to offset costs. Citing financial problems, Swedish American Hospital in Rockford closed its poison control center July 1 leaving the state with only one remaining center, at Rush-Presbyterian-St. Luke's Medical Center in Chicago.

The demise of SwedishAmerican's center marks the fourth such closing in 10 years. The other centers were operated by St. Francis Hospital in Peoria, St. John's Hospital in Springfield and the Pekin Center in Pekin. "Nobody argues that this isn't a valuable resource," said Rita Klint, the vice president of health and patient services at SwedishAmerican Hospital. "So many of the entitlements and funding from the

state of Illinois benefit just a given section of the population, [but] this particular service could potentially be used by every household in the state."

The closure of the Rockford center will mean that emergency departments in the 93 Illinois counties the center served will be forced to pick up its load. Rush's center will serve the 7.7 million residents of Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry and Will counties. Because of its own funding problems and its handling of about 50,000 phone calls per

year, Rush's center cannot absorb the 30,000 to 40,000 calls that were answered annually by SwedishAmerican's center, according to Jerrold Leikin, MD, medical director of the center at Rush.

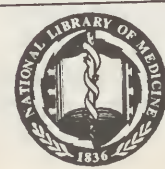
Poison control centers operate 24 hours a day, seven days a week, 365 days a year. Most of the costs, Klint said, stem from the salaries of people who answer the telephones. The state provided funding for only one fiscal year – 1994-95 – with SwedishAmerican receiving a total of \$50,000 and Rush \$100,000.

(Continued on page 13)



Amy Rothblatt

AND AWAY THEY GO as part of the American Hospital Association's "Hospitals Run for America's Health" 5k run Aug. 25 along Chicago's lakefront. AHA donated \$5 per runner to United Way/Crusade of Mercy, which helps 2.5 million Chicago-area residents each year.



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HCFA delays HMO incentive deadline

FINAL RULE: Managed care plans now have until Jan. 1 to insure physicians they put at financial risk. BY KATHLEEN FURORE

[WASHINGTON] The U.S. Health Care Financing Administration has extended the effective date of the physician incentive final rule for Medicare and Medicaid managed care plans from May 28, 1996, to Jan. 1, 1997, according to HCFA administrator Bruce Vladeck. The rule, published in the March 27 Federal Register, requires health plans to provide stop-loss insurance to limit incentives for inappropriate underutilization. Prepaid plans offering incentives that put providers at "substantial financial risk" must "provide adequate protection to limit financial losses." HCFA considers risk to be substantial if more than 25 percent of a physician group's potential payment is at risk for services it does not provide.

Primary care physicians who practice in capitated systems, for example, are liable for the costs of specialty care to which they refer their patients. That arrangement could be considered an incentive to minimize referrals, since the more referrals the physicians make, the lower the payments they retain. Under the new rule, physicians who meet the substantial risk criteria must receive protection from prepaid plans for 25 percent of the total potential payments or a fixed amount per patient. The number of patients the physicians serve will deter-

mine the amount, according to the Department of Health and Human Services, which oversees HCFA.

"The Clinton administration has always been committed, and remains committed, to implementing this regulation completely and vigorously, and we have made this clear to the HMO industry," Vladeck said. "Virtually all provisions of the regulation were to go into effect with Medicare contract renewals on Jan. 1, 1997, and that will still occur.

The decision by HCFA announced on May 28 merely changes that effective date [for the stop-loss provision] to conform with the other requirements of the regulation and with Congressional intent."

Those other requirements state that managed care organizations must disclose their physician incentive plans to HCFA or to the state Medicaid agency and, on request, to plan patients. In addition, the requirements prohibit plans from making payments to physicians specifically for limiting or reducing medically necessary services for an individual enrollee.

The final rule implements the 1990 budget reconciliation law and applies to doctors who provide medical care

through HMOs, competitive medical plans and health insuring organizations.

John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee, said the final rule is in patients' best interest. "It also protects the physician who finds that a patient needs extensive care."

The ISMS-developed Managed Care Patient Rights Act, introduced last February in the Illinois General Assembly and to be reintroduced after review, aims to instill confidence that health care providers are advocating on patients' behalf for medically necessary health care and entitles patients to clear information about the terms and conditions of their health care coverage. ■

ISMS offers free speaker training seminars

CME: Physicians can earn credit, develop speaking skills.

BY JANE ZENTMYER

[CHICAGO] ISMS is offering a series of free speaker training seminars throughout the state this fall. The programs allow physicians to earn continuing medical education credit while developing skills they can use as volunteers in the ISMS Speakers Bureau.

Speakers Bureau participants give presentations at schools and other educational forums that request speakers on health-related issues. They work with ISMS staff to schedule engagements that fit their schedules and specialties.

At the training seminars, public

speaking professionals will provide tips on delivering effective speeches and will conduct breakout sessions on three topics – teen AIDS awareness, seniors' issues and ISMS' Managed Care Patients Rights Act.

ISMS is accredited by the Accreditation Council for Continuing Medical Education, and physicians who attend the speaker training seminar can earn 3 hours of Category 1 credit toward the AMA Physician's Recognition Award.

Workshops, including dinner, will be held from 6 to 9 p.m. on Sept. 18 at the

Holiday Inn in Moline, Sept. 19 at the Clock Tower Inn in Rockford, Sept. 25 at the Holiday Inn Brandywine Hotel in Peoria, Sept. 26 at Jumers Restaurant in Champaign, Oct. 1 at the Lake County Medical Society headquarters in Vernon Hills, Oct. 3 at the ISMS headquarters in Chicago, Oct. 10 at the Marriott Suites in Downers Grove, Oct. 16 at the Hilton in Springfield, Oct. 17 at the Holiday Inn in Collinsville and Oct. 30 at ISMS headquarters in Chicago.

Physicians may register by telephone by calling (800) 782-ISMS, ext. 1303 or 1297. Or complete the form attached to page 12 and mail it to ISMS, Public Relations Division, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602 or fax it to (312) 782-2023. ■

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Wheeling officials identify inappropriate use of handicapped-parking placards

COMPLIANCE: Physicians should make sure patients meet one of six criteria. BY JANE ZENTMYER

[WHEELING] The disabled are more mobile today than they've ever been, according to Sue Ellen Burlini, assistant director of social services for Wheeling Township. That was the rationale for granting permanent handicapped-parking placards allowing the disabled easier access to buildings. That mobility plus the burgeoning senior population may account for the significant statewide increase in the number of placards issued in Illinois. Dave Urbanek, a spokesperson for the Illinois secretary of state's office, said that 31,031 placards were issued in 1991, but that number jumped to 73,767 in 1995.

Not all the placards issued conform to legal requirements, however. Under state law, physicians must sign a form issued by the secretary of state that authorizes their patients to receive a permanent handicapped-parking placard, which is effective for four years. To qualify, patients are required to meet at least one of six conditions listed on the form. When Wheeling Township considered developing more parking for disabled residents in 1995, its Advisory Committee on Disabilities discovered that more than one-third of the physician-authorized local requests failed to meet any of the legal criteria, Burlini said.

Patients meet one of the six conditions if they cannot walk 200 feet without stopping to rest; cannot walk without a brace, cane, crutch, another person, a prosthetic device, wheelchair or other assisting device; are restricted by lung disease to such an extent that their forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 mm/hg on room air at rest; use portable oxygen; have a cardiac condition to the extent that their functional limitations are classified as Class III or Class IV in severity, according to the American Heart Association's standards; or are severely limited in walking ability because of an arthritic, neurological or orthopedic condition.

Burlini said placards are issued for arthritis but should be given only to those severely limited by the inflammation. "We're trying to educate our seniors that they don't need a card necessarily."

The Wheeling advisory committee has also targeted physicians in an informational campaign. When doctors authorize requests for placards from patients

whose conditions are not defined by state law, they are in effect denying a parking space to someone who truly needs it, Burlini said.

The secretary of state's office has no plans for a statewide campaign, Urbanek said. "We just hope that physicians

would use caution in handing these placards out."

As part of Wheeling Township's initiative, a letter reiterating the six conditions was sent to all physicians in the area, which includes Arlington Heights, Mt. Prospect and Prospect Heights. "We were trying to figure out how we could reach doctors because we were certain they weren't aware this was a problem," Burlini said. In addition, the form used in Wheeling Township was changed to ask doctors to name the specific condition that applies to each patient.

Members of the advisory committee, 95 percent of whom are disabled, have

also checked on who is using the spaces, Burlini said. Often they have seen a healthy young person with a placard park in a handicapped-parking spot. A check of the car's license plate typically reveals that the vehicle is registered to, say, an 85-year-old who was issued the placard.

"The disabled placard should stay with the disabled person," Burlini said. The committee has advised those who already have placards not to loan them to anyone. And anyone driving someone with a disability should drop off and pick up that person at the door and park in a regular space, leaving the handicapped-parking spot open, she added. ■



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REPORT for Illinois Physicians

MEDICARE PART B

One of a Medicare carrier's key responsibilities under the Social Security Act is to identify cases of suspected abuse and fraud and, if necessary, refer these cases to the Office of the Inspector General (OIG), Department of Health and Human Services, for further investigation. The carrier also provides the Federal Bureau of Investigation information for health care fraud investigations that it may be conducting.

Abuse

Abuse applies to incidents or practices that are inconsistent with sound medical practices, such as:

- Charging excessively for services, procedures, or items.
- Submitting claims for services that are not medically reasonable or necessary.
- Breaching assignment agreements, with beneficiaries being billed for disallowed amounts.
- Exceeding limiting charge.
- Billing in excess of the fee schedule.
- Violating the participation agreement.
- Submitting claims to Medicare rather than to primary insurers.

Fraud

Fraud is intentional deception or misrepresentation, knowing it to be false, that could result in some unauthorized benefit. Examples are:

- Billing for services, procedures or items that are not provided.
- Altering claim forms to obtain higher payment.
- Intentionally submitting claims for duplicate payment.
- Soliciting, offering, or receiving a kickback, bribe, or rebate.
- Submitting Certificates of Medical Necessity (CMNs) completed by physicians who are not treating the medical conditions to which the CMNs apply.
- Misrepresenting the nature of services, procedures or items provided, the amounts charged for them, the identities persons receiving them, the dates they are provided, etc.
- Billing for noncovered services, procedures and items, as claims for covered services procedures and items.
- Submitting claims that involve collusion between between the provider and beneficiary.
- Using another beneficiary's health insurance certification number on claims.
- Submitting claims for services and procedures provided by an unlicensed person.

As the Medicare carrier for Illinois, the Health Care Service Corporation strongly encourages persons having knowledge of or questions about possible abuse or fraud involving providers, suppliers, or beneficiaries, to contact Medicare Part B at (312) 938-6955 or to write to Medicare Part B, Fraud Control Unit, P.O. Box 210, Chicago, IL 60690.

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EDITORIAL

A chic disorder

Remember the old days when people didn't want to be diagnosed as having medical problems and needing medication? These days, attention deficit disorder and Ritalin have become de rigueur for many Americans. In fact, Ritalin is so popular that production of the 30-year-old drug has increased 500 percent in the last five years, reported the New York Times citing statistics from the Drug Enforcement Administration.

Although there are many legitimate cases of ADD and uses of Ritalin, some physicians are concerned about its potential for misuse. They worry that the drug is being prescribed for children who have trouble paying attention but whose symptoms don't meet the diagnostic criteria and for adults who say they're easily distracted, according to the Times. The doctors question whether such a drug should be used without a clear diagnosis – for instance, simply to improve concentration.

The story quoted a psychiatrist who said he fears the diagnosis of adult ADD is becoming an excuse for any sort of psychological problem. He noted that people suffering from anxiety or depression are often inattentive but don't have ADD. As a result, the wrong problem is sometimes being treated.

An explosion in the diagnosis and treatment of learning disabilities is taking place only in the United States, according to the director of the Center for Bioethics at the University of Pennsylvania, who said in the Times that this aberration

should arouse suspicion. A chart in the Aug. 12 edition of Forbes magazine showed that the consumption of methylphenidate began steeply climbing in 1989 but only in the United States. Its usage has been fairly flat elsewhere. In addition, the increased misuse of Ritalin prompted its manufacturer, Ciba Pharmaceuticals, to launch a campaign last spring to inform the public about proper use of the drug.

Forbes also reported on the increasing number of teens who are qualifying for extended or untimed administration of college admission and licensing tests because of learning disabilities like ADD. The Educational Testing Services administered 35,000 such "nonstandard" tests out of the 2 million exams it gave this year – about double the number from four years ago.

The trend continues with graduate school admissions. Last year, 645 nonstandard Medical College Admission Tests were administered, more than five times the number of such tests five years before. Seven out of 10 of those special tests were administered because of ADD or learning disabilities, according to Forbes.

A geneticist interviewed by Forbes hypothesized that the increase in the number of of ADD cases and Ritalin use in the United States may be partly due to our societal reluctance to use behavioral approaches to work toward long-term goals. That theory may be worth considering.

PRESIDENT'S LETTER

What's the alternative – medicine, that is

Sandra F. Olson, MD



Chronic illnesses are thought by many physicians to lend themselves well to various alternative techniques.

It's a given fact that we Americans are fascinated with issues relating to our bodies and our health. We pride ourselves on having the most advanced and best medical care in the world. The sophisticated and advanced research that our scientists work on in many sectors is the envy of modern civilization. But lately there has been a wealth of attention and publicity given to alternative medicine.

Growing interest in this concept led to the establishment of the Office of Alternative Medicine at the National Institutes of Health, of all places, five years ago. It is charged with validating the various therapeutic measures considered to be outside established, traditional medical practice, and compared with other sections of the NIH, it has a small budget of almost \$7.5 million for 1996. To date, the office has not demonstrated or disproved the efficacy of any alternative therapy.

Life and Time magazines recently featured articles on this topic. Americans are proving their interest by spending upward of \$30 billion a year on alternative therapies and faith healers, along with millions more in related tapes, books, Web sites, etc.

Why has this segment of "medicine" grown so much in popularity and attention? It is now estimated that one in three Americans has tried alternative medicine. Have traditionalists missed something?

Many of these touted therapies are centuries old and standard in some cultures. Simple massage, or "the laying on of hands," is nothing new in medical lore. Faith healing has been practiced across the world in old and new cultures for centuries. Chi Gong, a Chinese energy healing technique, and shiatsu, a process of kneading "energy points" on the body, rather than inserting acupuncture needles, are all based the ancient theories of yin and yang forces. Acupuncture is probably the most accepted alternative technique of all.

Herbal and mineral therapies are booming – from feverfew for headaches to zinc for whatever. We can find a vast assortment of such remedies in supermarkets, which compete with local health food stores

and other shops touting "organic" products or natural remedies.

Traditional medicine tends to discount these therapies as scientifically unproven (lacking evidence-based data). However, it is interesting how some of our most mainstream drugs started out as natural remedies. The leaf of the foxglove plant, digitalis, was chewed hundreds of years ago by people who recognized that it helped "dropsy." Indians chewed willow tree bark for pain; we now call it aspirin. Mold led to penicillin; the yucca yew tree bark led to taxol. Examples of natural compounds harvested for the benefit of our patients abound, so we can't dismiss these remedies because we think a chemical spawned in a test tube experiment is always better.

But why have our patients become more enamored with such therapies while we spend increasing amounts of money to develop new technologies to treat our organic ailments? Acute illnesses such as infections, trauma, etc., clearly are not the fodder for alternative medicine. But chronic illnesses, such as pain, some forms of hypertension and stress-related disorders, are thought by many physicians to lend themselves well to various alternative techniques. Who's to blame patients if they seek nontraditional routes? We can't criticize them for taking charge, and actually that's what alternative medicine often preaches. If we feel helpless in certain situations, why shouldn't patients try alternative medicine as long as they are not harmed physically or monetarily? However, patients should always consult their doctor first.

This wave of enthusiasm for alternative medicine has splashed over into our medical schools. Thirty-four of the 125 U.S. medical schools now offer various courses in alternative medicine. The message to doctors is clear: Patients want help for what ails them and they'll get it wherever they can. Let's be sure we're always there for them.

If you'd like to share your feedback with me on this or other subjects, my e-mail address on the ISMS Web site is s_olson@isms.org. Our site can be found at <http://www.isms.org>.

Quotables

"There are fewer of us here, so patients may have to wait longer for a pain medication, or it may take longer for a patient's problem to be noticed."

— **Marva Wade**, OR nurse at Mount Sinai Medical Center, on nursing cutbacks in New York hospitals, New York Times

"Usage in the United States is way above clinical necessity. I'm quite convinced little boys are getting put on it because they're little boys."

— **Anne Moir, PhD**, on use of Ritalin for attention deficit disorder, Forbes

"Kids do it because they want to numb out."

— **Robert Sholtes, MD**, child and adolescent psychiatrist at Columbia Woodland Hospital in Hoffman Estates, on children's use of inhalants, Daily Herald

"We have a lifeboat designed to hold 15 people, and it has 35 people already. If people keep jumping in, we're going to lose everyone."

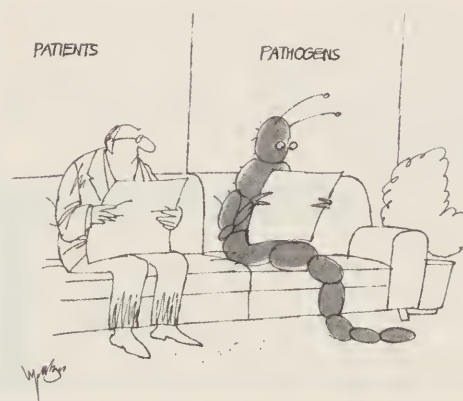
— **Hank Carde**, AIDS activist, on the rationing of AIDS drugs because of heavy volume of requests for new medications, Wall Street Journal

"Children are never going to get what they need until there is a fundamental change in the ethos that says it is acceptable to cut children first."

— **Marian Wright Edelman**, president of the Children's Defense Fund, on the priorities used in federal budget cutting, Time

"This survey turns conventional wisdom on its ear by revealing that millions of Americans actually are in touch with news and civically involved but still don't vote."

— **Ellen Shearer**, codirector of Medill News Service, on a survey that shows nearly half of Americans who are disinclined to vote are well-informed but think their vote isn't necessary or doesn't count, Chicago Sun-Times



LETTERS

Targeting gun control

I have just read the letter by Dr. Alan Froehling (July 19 issue) concerning violence prevention and gun control. I am dismayed and distressed concerning the "facts" and attitudes expressed in this letter. I have often encountered them in discussing gun control. In 200 years of our country's history, the Second Amendment of the U.S. Constitution has never been applied to individual gun ownership. That fallacy is a creation of the National Rifle Association and is usually expressed to avoid any intelligent discussion of gun control.

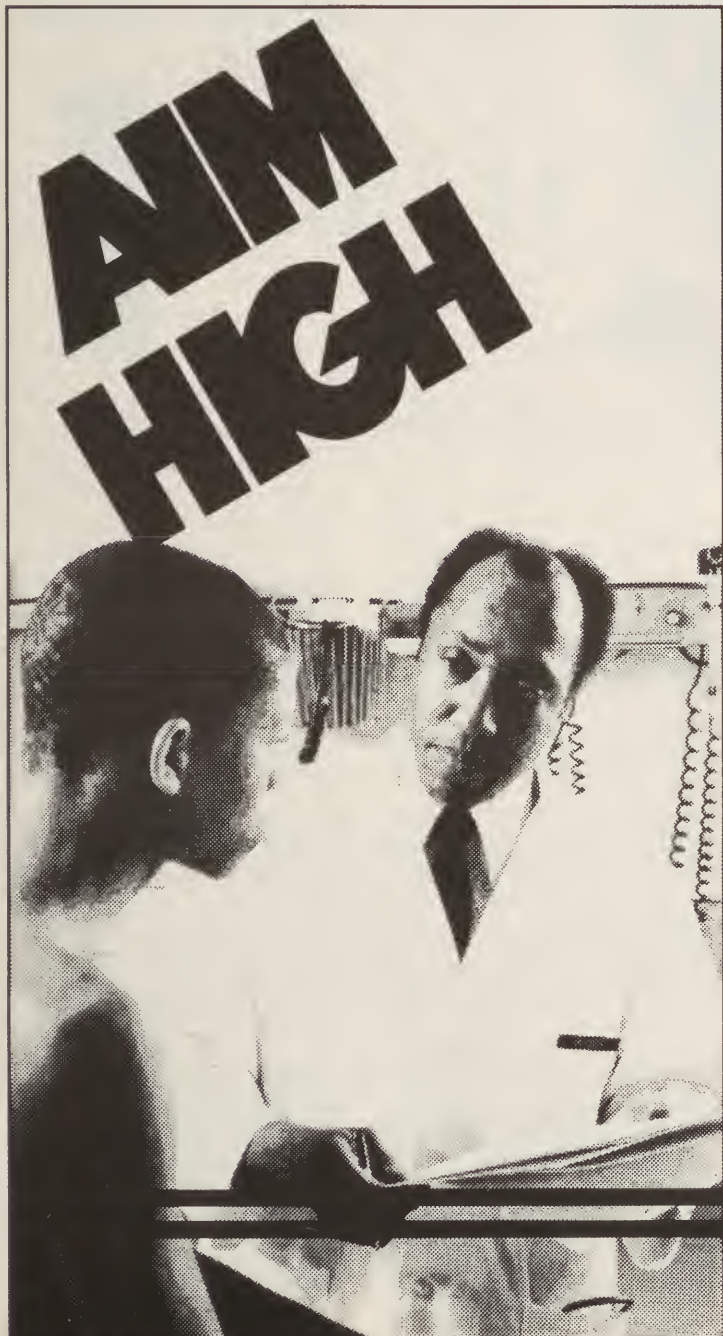
Local communities do and should have every right to enact ordinances to protect themselves through gun control or other means. Gun control advocates like me would not and have not support-

ed a ban on all guns, nor would we assume that doing so would eliminate violence. The comment that Florida has demonstrated reduced violent crime based on private gun ownership is absurd. Those studies are difficult to undertake, and the results are contradictory. However, the most dismaying point of this letter is the fact that a physician would think it inappropriate for the Centers for Disease Control and Prevention and the New England Journal of Medicine to be involved in what is clearly a major public health problem.

Although the author claims not to be some wacky Freeman, the rhetoric unfortunately sounds very familiar.

— **Dennis G. Norem, MD**
Rockford

Illinois Medicine reserves the right to edit all letters to the editor.



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Malpractice
Roundup

PAGE 7

ISMIE Update

Following advance directives can reduce liability

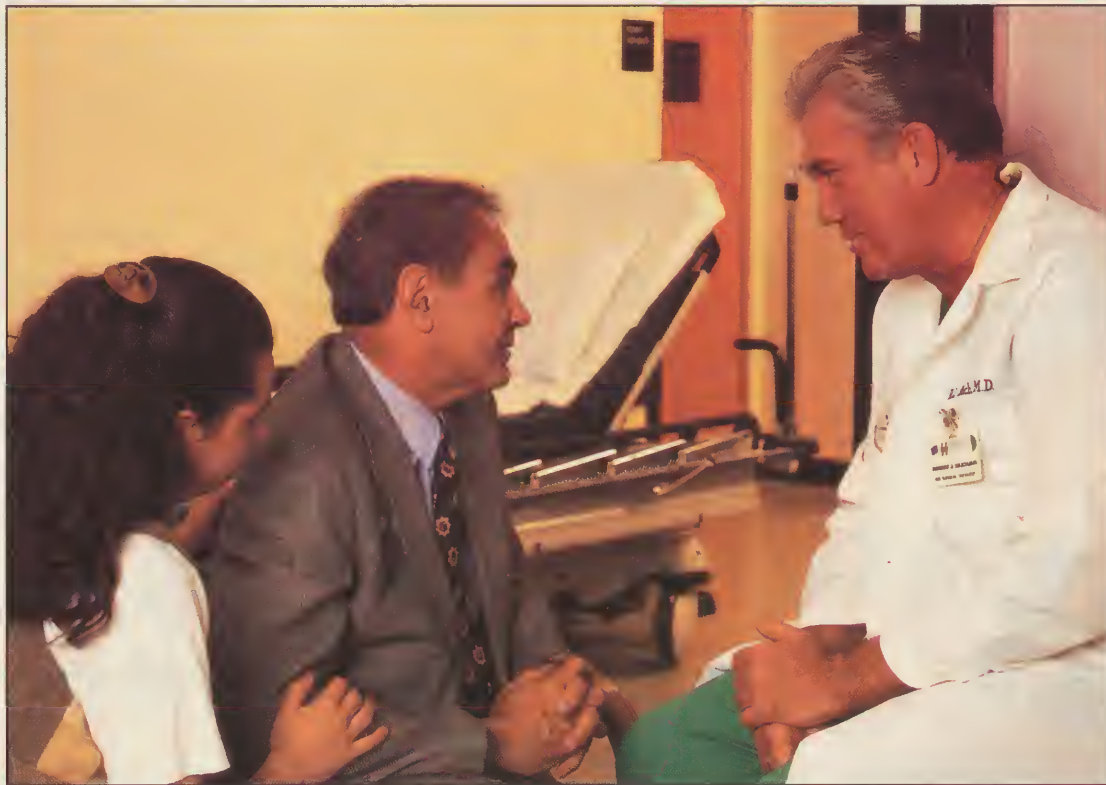
Attorney advises discussing patients' wishes before life-threatening situations arise.

BY KATHLEEN FURORE

Advance directives help ensure that physicians and family members follow a patient's wishes when death is imminent. But as a recent Michigan lawsuit shows, if directives aren't followed, they can create liability risks for physicians, hospitals and other health care providers.

In the Michigan case, a 38-year-old woman who was experiencing increasingly serious seizures signed an advance directive and gave her mother power of attorney to stop treatment if the daughter became incapacitated, according to a story in the June 2 edition of the *New York Times*. However, a month after signing that directive in 1992, the woman experienced a disabling seizure and was put on a ventilator, tube-fed and maintained through a two-month coma, even though the mother insisted her daughter didn't want such measures taken. The mother now cares for the daughter, who spends her days "rhythmically screaming and thrashing" and needs to be fed, bathed, diapered and tied into bed at night.

The *New York Times* article also cited cases pending in Arkansas, California, Indiana and Ohio in which patients and their families have sued physicians, hospitals and nursing homes for allegedly ignoring end-of-life directives. But in spite of what the *New York Times* called "a new wave of lawsuits" involving advance directives, a Chicago attorney said he is not aware of such a trend in Illinois. "I haven't handled any litigation in which someone says, 'My specific request to Dr. Smith was denied,'" said Roy Bossen, who is with Hinshaw & Culbertson and helps hospitals implement advance directive policies. "But it is a potential problem because you're creating a written document, so you have a paper trail



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to go back to and bring to the attorney. Before, someone could say, 'This is what I told you,' and it could be open for honest dispute. But with written advance directives there is a paper trail showing the doctor didn't comply."

The Michigan case raises the issues of physicians' legal and professional obligations to their dying patients and ways they can prevent such situations, Bossen said.

Illinois statutes spell out conditions under which living wills and other types of advance directives can be executed and establish physicians' responsibilities in dealing with patients and their families in end-of-life situations. According to the Illinois Living Will Act, for example, patients' intentions about life-sustaining treatment must be written, executed voluntarily and signed by the patients or another party whom they've directed. Attending physicians must certify those patients have

a terminal condition. And the patients, if able, must inform their physician of the existence of the living will.

Other applicable statutes include the Illinois Powers of Attorney Act, which allows patients to grant a durable power of attorney for health care to an individual authorized to make health care decisions if they become disabled or unable to direct the management of their care, and the Illinois Health Care Surrogate Act, which sets standards for making decisions about life-sustaining treatment for terminally ill patients who are unable to make or communicate decisions about their care but who have not executed a living will or durable power of attorney.

Although the laws specify that physicians must comply with a living will – or with the decision of the individual granted durable power of attorney or the surrogate, assuming that decision was made legally –

there are exceptions, Bossen said. "Under the acts, doctors are free to say, 'That's against my beliefs,' but they can't just abandon the patient and family." He cited a mechanism by which physicians can transfer a patient to another provider if they aren't comfortable treating them under the limitations of the advance directives.

Physicians who can't in good faith execute specific advance directives must promptly advise the patient or responsible party of their decision and "take all reasonable and appropriate steps to help transfer the patient and appropriate medical records to the care of another physician" who is willing to comply with the advance directive, according to the ISMS brochure "A Physician's Guide to Advance Directives." In addition, a physician who chooses not to follow an advance directive "must continue to provide reasonably necessary consultation and care in connection with the

transfer" and document the circumstances involved and the reasons he or she is unwilling or hesitant to comply, the ISMS guide says.

The statutes also give physicians immunity from liability in certain circumstances. Those who fail to follow the directions in a living will, for example, are immune from liability if they have acted legally and in good faith and have conformed with the standards of reasonable professional medical care and judgment. And unless a physician "has actual knowledge that a living will has been revoked, failing to act on such a revocation does not imply liability or unprofessional conduct," the ISMS guide says. Under the Powers of Attorney Act, physicians "will not be subject to any type of civil or criminal liability or discipline" for failing to comply with a decision by an individual granted durable power of attorney if they have acted in good faith, met reasonable medical standards, promptly informed the individual of their unwillingness to comply and cooperated in the patient's transfer to another physician. Physicians who in good faith rely on and follow a surrogate's directions and "act with due care according to the law" are immune from civil or criminal prosecution or discipline, the ISMS guide states.

But there are gray areas, Bossen said. "There are statutory short forms [for advance directives] printed right in the statutes that meet the requirements of the law." But the information in such a document may not tell physicians exactly what to do, he added. "It might meet the requirements of the law, but does the patient truly understand what he or she is directing the physician to do? And does the physician understand what the patient is directing the physician to do? Either

the sender or receiver could take a different interpretation."

In fact, a misunderstanding about what constitutes life-sustaining measures apparently played a role in the Michigan case. According to the New York Times story, the physicians involved asked the mother for consent to ventilate her daughter, begin dialysis, administer dopamine and start blood transfusions. But the attorney representing the family said the mother — who has only a fifth-grade education — "had no idea what she was consenting to. And no one really explained it."

That example underscores the importance of physician-patient communication about advance directives before death becomes imminent. "Physicians should try to deal with the issue up front, hopefully before the patient goes into the hospital or nursing home," Bossen stressed. "The classic risk management story is that a technically proficient physician may be sued as much if not more than one who is not as proficient because the latter took more time to meet with the patient and family." Bossen advised physicians to use office visits to discuss patients' wishes about life-sustaining treatments and to include patients both young and

old. "Doctors have to be attuned to dealing with the issue head-on, early on, and not only for old or terminally ill patients. A young person could be in a traffic accident, and his or her wishes wouldn't really be known."

ISMS House of Delegates policy on withdrawing or withholding life-prolonging treatment is that the "social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his/her family or legal representative (if the patient is incompetent to act in his/her own behalf) should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient."

ISMS offers kits called "A Personal Decision" that physicians may give to their patients. The kits contain information and forms related to living wills, power of attorney for health care and organ donation. For ISMS members, the first 100 kits ordered are free, and thereafter the cost is \$40 per 100 copies. For nonmembers, the cost is \$40 per 100 copies. To order, physicians may call (312) 782-1654 or (800) 782-ISMS, ext. 1221. ■

MALPRACTICE ROUNDUP

Damages limited in case of failed tubal ligation

An Illinois appellate court ruled that a woman who became pregnant after a tubal ligation could recover damages related to the pregnancy but not to the costs of rearing the child, according to the July issue of Medical Malpractice Law & Strategy.

In *Williams vs. University of Chicago Hospitals*, the patient underwent a tubal ligation after experiencing complications from two pregnancies and delivering a child who suffered from learning disabilities. Seven years after the procedure, the patient became pregnant and gave birth to another learning-disabled child. She subsequently sued the hospital to recover damages for the future medical care of the child as well as for the pregnancy.

The court found that the birth of a child with a learning disability is not a reasonably foreseeable result of an unsuccessful tubal ligation even if the mother previously delivered a baby with a birth defect. It held that plaintiffs in such cases can recover expenses for the pregnancy, the delivery, lost wages, loss of consortium and pain and suffering, but not for future child rearing. ■

Negligence in diagnosing, treating infection results in award

A family was awarded \$6.2 million after filing a suit alleging negligence to diagnose and treat a massive infection resulting from a child's burns, according to the June 17 *National Law Journal*.

In *Henry vs. Blotny*, a 22-month-old fell into a small tub of scalding water sustaining burns over 25 percent of his body. He was taken to a Baltimore burn center for treatment, and within two days he was transferred from the burn unit to the pediatrics floor, according to the plaintiff attorney. It was then that his condition deteriorated with "recognizable signs of dehydration and infection, calling for treatment with intravenous antibiotics," the attorney said.

Despite "alarming changes in the white blood count," there was no reaction from medical personnel, and the child died six days after being admitted to the center, according to the *Journal*.

The defense contended that the death was related to the burns, but the jury found for the plaintiff. The case is being settled. ■

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When is a nursing home the right choice?

A new state program will help the elderly and their families understand the options.

BY JANE ZENTMYER

With Americans living longer today, more and more families are facing the decision of whether to place relatives in nursing homes or care for them at home. Physicians can and should play a pivotal role in helping patients and their families understand the social and medical issues that should be factored into that decision.

"What the patient and family believe is right is very important in that decision because there's almost nothing you can't do in-house," said Joan Cummings, MD, a geriatrician and network director of the Veteran Integrated Service Network at Edward Hines Jr. Hospital in Hines. "Whether or not it should be done in-house depends on a whole host of things, including the patient and family's attitude toward it. The only way to find out is to ask them."

The decision made by families often depends on the social structure available to care for elderly relatives, Dr. Cummings said. Much of the "high-tech stuff" such as giving IV medications can be done at home if the support structure is there to help provide care, she explained.

"There are some individuals with exactly the same care needs where one individual is very comfortable going home with family and the other believes the nursing home is the only appropriate setting," Dr. Cummings said.

Jack Bulmash, MD, a senior attending physician in geriatrics at Rush-Presbyterian-St. Luke's Medical Center in Chicago and ISMS' representative on the state's Long-Term Care Facility Advisory Board, said physicians help coordinate services for patients who need long-term care. And when patients and their families decide whether a nursing home or home health care is more appropriate, they should consider the following questions: Could this patient receive home infusion therapy? Can relatives and friends fill in the gaps? Can the patient reasonably move in with a friend or stay at home with his or her spouse? Can the friend or spouse be relieved by help from children? Is day care a possibility for a patient who suffers from dementia and whose spouse or child has to work?

Making the best choice involves weighing the specific medical needs, which may or may not require the relative to live in a nursing home, the level of custodi-



Rick Kroninger

al care needed and the family's ability to provide that care, said William Kobler, MD, ISMS 12th District trustee and a Rockford family physician.

Educating patients about options other than nursing homes is the goal of a new state program that requires prescreening of all individuals entering nursing homes regardless of whether they plan to pay with their own funds or through Medicaid. "This program is giving us the opportunity to bring new visibility to programs and services for older people," said Jan Costello, a spokesperson for the Illinois Department on Aging.

The prescreening program, called "Choices for Care," was approved by the General Assembly and Gov. Jim Edgar as part of the 1995 budget, and it was implemented in July 1996. Although at least five state departments are involved in the program, IDA will have most of the related workload because of the population it serves, Costello said.

IDA has contracted with area agencies to provide case managers from the community to conduct the prescreenings. Those case managers will conduct a determination of need, through which they will assess elderly individuals' ability to bathe and groom themselves and maneuver in their home. Based on their findings, case managers will then review each person's options with that individual. The program cannot prevent people from entering nursing homes if that's the final decision, Costello said, but it does require them to hear about alternatives. In certain situations, the law does provide for exemptions from prescreenings or for some screenings to be completed after patients are in a nursing home.

Case managers may work with physicians, patients and their families to help find other options that would meet a person's custodial and medical needs,

(Continued on page 10)

When is a nursing

(Continued from page 9)

said Jeff Pentzien, an IDA trainer. If a physician recommends that a patient be placed in a nursing home, that recommendation stands, he explained. Sometimes IDA sends a case manager to conduct a determination at a patient's request. In such a situation the case manager might contact the patient's physician to find out about the elderly person's medical condition. In addition, case managers might consult physicians if patients seeking nursing home care haven't contacted their physician.

For patients to participate in some services that might be recommended by the department, a physician's approval is necessary, Pentzien said. Those services include adult day care through the Community Care program and are aimed at those 60 or older who meet the program's financial requirements. Case managers might also know of other programs offered locally, such as home-delivered meals, which might help seniors who are trying to stay in the community and out of a nursing home, he added.

The state prescreening program is driven not only by a desire to help elderly patients determine the most

appropriate residence for themselves but also by financial concerns. About 88,000 people lived in Illinois nursing homes in 1994, the most recent year for which figures were available. Of those, 66,000 were covered by Medicaid, according to Dean Schott, a spokesperson for the Illinois Department of Public Aid. Schott provided the following statistics: The typical resident is 81 years old and female. About 87 percent of residents are 67 years of age or older. The other 13 percent are people who require care for a limited time because of a temporary disability. Sixty-six percent of those 65 and older stay in a nursing home more than a

year. To qualify for Medicaid funding, seniors must have no more than \$2,000 in assets, not including their house.

State officials said they hope that informing the public about available options will help trim the \$1.5 billion that Medicaid spends on long-term care in Illinois. "The idea is to educate persons who are about to enter long-term care facilities about their available choices and to help them determine whether or not it is appropriate for them to be in a long-term care facility," Schott said. "If there is some less-expensive alternative, [choosing] it would help conserve the financial resources for that person and the family and therefore their ability to secure care over a longer period of time. It would also potentially delay the date when they would qualify for coverage under Medicaid."

BEFORE THE INCLUSION of private-pay individuals in the prescreening program, IDA prescreened 13,000 people annually. The department projects that it will conduct 92,000 evaluations annually, Costello said. This year's state budget allocates \$2.8 million to administer the expanded program. State officials said they hope to save \$39 million through the program by deflecting about 3 percent of the people considering nursing home care to other sources of health care.

The Illinois auditor general's office will examine the program in two years and determine whether it has produced the expected cost savings, said Kirk Riva, vice president of public policy for Life Services Network of Illinois. The group includes more than 300 organizations that serve 45,000-plus people who require residential health care, retirement housing, assisted living or home and community-based services.

As with most new programs, some people, including Riva, are reacting cautiously. "We don't feel that private-paying individuals should be prescreened once they make a very private and difficult decision to put a family member in a nursing home," he said.

Dr. Bulmash said he's not sure whether the program will affect his work. "We are real careful about who we send to nursing homes. This is a last-resort placement rather than a first-resort placement unless, of course, we know it's a short-term thing or a specific rehab focus."

A few people may use nursing facilities as hotels, but those instances are rare, said Dr. Bulmash. He said he understands why the program might be needed when taxpayers' money is involved, but added that the program seems intrusive for those who can afford to pay for nursing home care. "It remains to be seen how effective this is and whether it's worth it."

Helping the elderly and their families make decisions about long-term care is an IDA mission supported by additional educational efforts, Costello said. For example, IDA operates a toll-free senior hot line, which receives 42,000 calls annually. A guidebook is being developed that will explain Choices for Care and other programs and will list such resources as local senior centers and case management agencies. The department is also holding more than 20 symposia around the state to help the public and the medical community find out more about the prescreening program. For more information, call IDA at (800) 252-8966. ■

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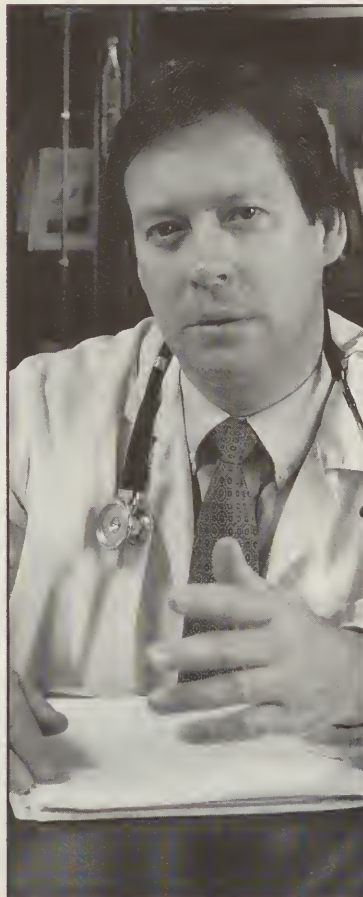
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SwedishAmerican

(Continued from page 1)

The Illinois General Assembly has previously considered but not approved the provision of state funding for poison control centers by such means as a 10 cent surcharge to each household telephone bill, but the proposals have stalled, according to John Lumpkin, MD, director of the Illinois Department of Public Health. "There was really no support in the legislature to do that. I think that these facilities serve an important role. It's unfortunate that there appears to be no support for public funding for poison control. The problem is that there are so many competing priorities for state funds."

SwedishAmerican estimated it would need at least \$160,000 this budget year to keep the center operating, Klint said. Operating the Rush center requires between \$1.1 million and \$1.5 million annually, and the center is facing a funding deficit of \$300,000 in 1996, according to Dr. Leikin. "It is ironic that preventive medicine and home health care are becoming larger forces in medicine and that poison control centers are being squeezed out in this state," he said. "It's a public health embarrassment."

The Metropolitan Chicago Healthcare Council is working to raise the necessary private funds from its members and the community to assume the administration of the poison control center at Rush, said Karen Hughes, MCHC's vice president. "We feel that

this is a very valuable community resource and should not be allowed to die." MCHC is asking its members for three-year commitments for funds and hopes to reach its funding goal by Oct. 1, Hughes noted. She added that several years ago there were 400 poison control centers nationwide, and only about 85 still exist.

Poison control centers were developed to keep people from making visits to hospital emergency departments and to save money. The Rush center, established in 1953, was the first poison control center in Illinois and in the nation. In 1979, IDPH designated Rush's center as a regional poison control center for Chicago and northeastern Illinois, according to MCHC.

AT THE RUSH CENTER, eight to 10 physicians volunteer their services, Dr. Leikin said. The physicians, nurses and poison information specialists field hundreds of calls daily on topics ranging from overdoses to venomous bites, and in 1995 they handled 72 percent of all calls without having to refer patients to the emergency department, according to MCHC. The Rush center saved an estimated \$3.5 million in unnecessary emergency department and office visits in 1995, MCHC said. National figures show that every \$1 spent on a poison control center saves between \$4 and \$9 in medical expenses, according to MCHC.

The Rush center also stocks rare antidotes and antivenoms; offers toxicology training to pharmacy and medical stu-

dents, residents and pediatric fellows; tracks trends in poisonings; and along with Cook County Hospital and the University of Illinois Hospital, participates in a consortium that offers local institutions a 24-hour toxicologist for backup on difficult cases.

About 20 percent of the calls to the

Rush center are from other health care professionals seeking advice, Dr. Leikin said. Emergency departments have been advised to purchase databases to help them with poisoning cases, but poison control center staff are always up-to-date on the nuances, he added. "You can't replace experience." ■

Chicago infant mortality rates stable

[CHICAGO] The 681 infant deaths reported in Chicago in 1995 marked an all-time low, according to epidemiologists at the Chicago Department of Public Health. Data released in August showed that for every 1,000 live births last year, 12.5 infants died before their first birthday. That 1995 figure matches the one for 1994 and improves on the 1993 rate of 13.7 deaths for every 1,000 live births.

Glenn Good, a senior epidemiologist with CDPH, said the figures are encouraging. "The magnitude of improvement has been significant in the past 15 years." Nearly 55,000 births were reported in 1981 and again in 1995, but there were 365 fewer infant deaths in 1995.

The drop appears to be related to a reduction in sudden infant death syndrome and deaths stemming from respiratory conditions, according to CDPH. The SIDS decline might correspond to the increasing practice of putting babies to sleep on their backs or sides instead of their stomachs, health officials said. Data also shows that women who reported

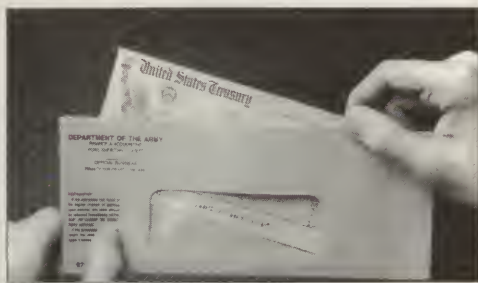
smoking during pregnancy decreased from 15.6 percent in 1989 to 9.9 percent in 1995.

While the overall infant death rate has dropped to an all-time low, the gap between Chicago's black and white infant mortality rates narrowed as the result of increased mortality among white infants, health officials said. The 1995 rate for black infants remained at its 1994 low of 8.3 deaths per 1,000 live births while the 1995 rate for white infants rose from 7.5 deaths per 1,000 live births in 1994 to 8.3 deaths per 1,000 live births in 1995.

To help reduce the city's infant mortality rate, CDPH offers such services as a network of public health clinics typically located in the most needy neighborhoods and mobile immunization teams that vaccinate infants and toddlers. CDPH Commissioner Sheila Lyne, RSM, said that despite some encouraging data, efforts to lower infant mortality rates must continue. "We must understand that Chicago's rate, like the infant mortality rates in all major U.S. cities, remains unacceptably high." ■

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Doctors collect books for underprivileged kids

BOOK DRIVE: Summer program at Loyola University Medical Center promotes literacy. BY RICK PASZKIET

[MAYWOOD] This summer, physicians at the Loyola University Medical Center collected and distributed more than 1,500 books to underprivileged children who are patients at the medical center in Maywood, as well as at its neighborhood clinics.

"The idea for holding a book drive was initiated after I attended a national meeting of the American Academy of Pediatrics," said Gretchen Kind, MD,

chief pediatrics resident at Loyola. "The meeting taught physicians how to promote literacy, especially among children who come from foster homes or whose parents are on public aid. One way to encourage literacy is by making sure children have access to books."

Dr. Kind said she had hoped to collect 600 books from Loyola physicians and staff, but with the help of Lorene Freehill, MD, a third-year pediatrics resident,

the drive exceeded her expectations.

In addition to promoting the drive through word of mouth, Dr. Freehill "developed a computer screen saver that provided Loyola faculty, staff and students with information about the book drive and produced and distributed fliers throughout Loyola's medical center, its community clinics, and neighborhood elementary schools," Dr. Kind said.

Dr. Freehill said she became involved because promoting literacy should be a top priority for pediatricians. "Not only are we giving books to children, but we are also encouraging parents to read to their children," she explained. "Studies

have shown that children develop better verbal and cognitive skills if they are read to at an early age. They also tend to learn faster."

Dr. Freehill said she hopes that the program will be expanded next year. "We will ask neighborhood elementary schools to donate any books they don't need," Dr. Freehill said. "In fact, this year the children from Notre Dame Catholic elementary school in Clarendon Hills contributed two sets of encyclopedias. We'll use these for our Loyola school program, which keeps hospitalized children on schedule with their studies while they recover." ■

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Statewide meetings

(Continued from page 1)

nois residents and must either be licensed to practice medicine in Illinois or have voluntarily surrendered their license to practice. The offering is aimed at Illinois physicians to ensure the company will always be physician-directed, according to Chairman of the Illinois Medical PSO's Board of Directors Edward Fesco, MD. The purchase price is \$1,000 per share, and a minimum investment of five shares of voting-participating preferred stock is required. Investors who make that minimum purchase can buy up to 10 additional shares of nonvoting-participating preferred stock. The stock offering is scheduled to expire Oct. 19.

In addition to the meeting at which Dr. Jackman spoke, several other programs have been held in conjunction with county medical society meetings. In July and August, meetings were conducted in Madison, Rock Island and Winnebago counties.

The following programs have been scheduled for the fall: Sept. 16, Adams CMS; Sept. 17, Lake and Macoupin CMS; Sept. 18, Greene and Jersey CMS; Sept. 19, Marion CMS; Sept. 24, DuPage and Jackson CMS; Sept. 25, Macon and McLean CMS; Sept. 26, Fulton CMS; Oct. 1, Vermilion CMS; and Oct. 15, Peoria Medical Society. Physicians interested in finding out more about the meetings, the Illinois Medical PSO or the stock offering may phone (312) 551-2377 or (888) ISMS-PSO. ■



Perry Rech

HONORED FOR HELPING STAFF members solve computer problems so that they can better serve ISMS members, Carl Block is the most recent recipient of the Society's Employee Recognition award. Block is the production support administrator in the information systems division.

ICPV hosts statewide violence prevention conference

Physicians who treat the victims of violence can learn new strategies for preventing violence and connect with others in Illinois who are working to prevent violence at "Creating Peaceable Communities," a statewide conference to be held Oct. 4-5 at the Ramada Congress at 520 South Michigan Ave. in Chicago. Sponsors include the Illinois Council for the Prevention of Violence, ISMS, the Illinois Department of Public Aid, the Illinois Public Health Association and 33 other associations and agencies concerned about preventing violence.

The conference will offer 32 workshops on such topics as prevention of elder and child abuse and health systems' approaches to violence prevention. In addition to health and criminal justice professionals, many educators, service providers, representatives of community organizations and policy-makers are expected to attend.

"This conference can help people in medicine see themselves as part of a larger community effort to prevent all

forms of violent behavior," said Barbara Shaw, ICPV executive director. "Health care professionals will learn there are many agencies and associations to which they can refer patients — those who are prone to violent behavior and those who are victims. They will also see that they can play a vital role in educating their patients about preventing violence."

Physicians participating in the conference include Frank Thorpe, MD, a pediatrician at the University of Chicago Hospitals and chairman of the task force that will present a workshop on prevention of corporal punishment. In addition, Chukwudi Onwuachi-Saunders, MD, deputy health commissioner for Philadelphia, will be the opening keynote speaker.

Prior to Sept. 20, registration for the conference costs \$100 for ICPV members and \$135 for nonmembers. After Sept. 20, registration is \$120 for ICPV members and \$155 for nonmembers. For more information, call (312) 986-9200. ■

HCFA proposes

(Continued from page 1)

the work RVUs for some 7,000 Current Procedural Terminology and HCFA Common Procedure Coding System codes. According to the Social Security Act, all work RVUs must be reviewed at least every five years. And since HCFA implemented the physician fee schedule effective for services furnished beginning Jan. 1, 1992, that review was due before 1997, the analyst noted.

About 3,500 of those codes were also

referred for subsequent review to the AMA Specialty Society Relative Value Update Committee (RUC), which is composed of representatives of major specialty societies, the AMA, the American Osteopathic Association and the CPT Editorial Panel.

AMONG THE FACTORS considered in evaluating the codes and assigning the proposed RVUs were the time physicians spent performing specific services, the extent to which those services had changed over the last five years and the mental effort

required to deliver the services, the analyst said.

"It is required by law that the review be done. And the results in large part were supported by the physician reviewers on the AMA's Relative Value Update Committee," explained John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. "Therefore the results in general would appear to be reasonable." But he cautioned that not all physicians will benefit, since changes to the RVUs are made in a budget-neutral fashion. "Unfortunately,

every time somebody gains a dollar, somebody loses a dollar."

Overall, HCFA is proposing to increase the work RVUs for 28 percent of the codes; to maintain the current RVUs for 61 percent; and to decrease them for 11 percent. The proposed RVUs agree with the RUC's recommendations for 93 percent of the codes, the analyst said. Specialties that would benefit most from the proposed changes include family practice, which would see a 4.6 percent increase in Medicare physician payments over the current work RVUs, and internal medicine, which would get a 4.2 percent boost. In addition, hematology/oncology payments would increase by 3.9 percent; emergency medicine by 3.7 percent; pulmonary medicine by 3.6 percent; general practice by 3.5 percent; and rheumatology by 3.4 percent. Providers who would experience cuts include dermatologists, with a 6.2 percent decrease; anesthesiologists, with a 4.7 percent decrease; chiropractors, with a 4.6 percent decrease; optometrists, with a 4.5 percent decrease; and pathologists, with a 4.2 percent decrease, the analyst said.

The total impact of the proposed changes, however, will probably be balanced by anticipated changes to the fee schedule conversion factors for 1997, Dr. Schneider said. "For example, if the conversion factor increases by 3 percent next year and if you experience a 3 percent cut [as a result of the proposed RVUs], you'll be even." ■

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PAGE 12



Maureen Houston

DOCTORS DISCUSS the Illinois Medical Physician Services Organization after a Sept. 5 presentation in Belleville. Attendees chatting are Vijay Aher, MD (left to right); Ronald Welch, MD; Silvana Menendez, MD; and Ventrapragada Mohan, MD.

Control of Illinois General Assembly up for grabs

GENERAL ELECTION: The outcome of races in key House and Senate districts will determine whether legislature continues to be friendly to medicine.

BY JANE ZENTMYER

[CHICAGO] With the Nov. 5 general election just more than a month away, candidates seeking seats in the Illinois House and Senate have stepped up campaign efforts. Physicians can and should get involved in the election by determining which candidates will help create a legislature that's receptive to physicians and patients, according to Jere Freidheim, MD, chairman of the Illinois

Medical Political Action Committee. "It's important for physicians and their families to get involved at the local level to help candidates who have supported or are willing to support and protect quality health care," he said. "IMPAC will be educating physicians in many districts about the candidates and urging physicians to become involved in their local races.

"We will also be heavily involved in supporting those candidates who supported tort reform," Dr. Freidheim continued. "But we are also looking ahead to future issues, like managed care, that affect physicians and patients."

In 1994 Republicans assumed control of the House for the first time in 12 years with a

64-54 majority.

In that same election the GOP in the Senate increased its majority by one seat to 33-26, and Gov. Jim Edgar overwhelmingly beat his challenger. The resulting physician-friendly atmosphere allowed tort reform legislation to pass both chambers in 1995 and be signed into law by Gov. Jim Edgar, culminating a 20-year effort by ISMS.

While the Illinois courts are now deliberating the future of various provisions of tort reform legislation, including the cap on noneconomic damages, supporters of tort reform are still needed in the General Assembly to prevent efforts to reverse the progress made during the past two years.

"Anything that was passed can always be undone," said Sen. Dave Syverson (R-Rockford), a tort reform supporter who is seeking his second four-year term as a state senator, this time in a race against Carol Jambor-Smith (D-Rockford). "You can't sit back after having a couple of victories and say, 'Now we've done our job, and we can go back home.' Physicians need to continue to be proactive in the defense of their patients and in making sure that Illinois is the best place in the country in regard to families' health care and well-being."

Rep. Gwenn Klingler (R-Springfield), who is married to a physician and finishing her first two-year term, said physi-



Klingler

Ron Ackerman

Doctors lead Baltimore-Washington MSO

MANAGED CARE: Physicians retain control and expand practices. BY TODD SLOANE

[OWINGS MILLS, MD.] Through a regional management services organization, doctors in southern Maryland and northern Virginia are banding together to assert some control over their future under managed care. Some 270 primary care physicians are majority owners of Doctors Health System, based in Owings Mills, Md. Another 800 doctors, many of them specialists, have become affiliated with DHS through independent practice associations that have referral arrangements with the system or that contract for practice management support services.

DHS will soon announce an

agreement with a number of specialists who will join as owners, making the MSO one of the major players in health care in the Baltimore-Washington, D.C., corridor, according to Stewart B. Gold, DHS chief executive officer. Eventually, DHS may expand as far as West Virginia and lower Pennsylvania.

In the little more than two years since it was founded, DHS has raised \$73 million in private capital to finance this acquisition binge, in the process putting together a patient base of nearly 500,000, Gold said. Driving this expansion is a fast-changing market in which HMOs and

other managed care players have squeezed reimbursement rates and imposed protocols on the timing and types of care physicians may order for their patients, he explained.

"We have shown physicians that by working together, they still can be significant players under managed care," said Scott Rifkin, MD, an internist and DHS chairman. "We are physician owned and physician run, and we have the critical mass to contract for better rates."

By negotiating full-risk, or global-capitation, contracts with Medicare and commercial-pay

(Continued on page 17)

Illinois Medical PSO to be unique in Illinois

The Illinois Medical Physician Services Organization Inc. is another model of what are generically called management services organizations.

Once capitalized, the Illinois Medical PSO will be an independent, for-profit corporation dedicated to providing solo practitioners and physicians in group practices with support and services in negotiating and contracting, practice development, managed care operations, administrative and financial planning, and capital

formation. It will be owned by physician investors in the company's preferred stock and the Illinois State Medical Holding Co., a wholly owned subsidiary of the Illinois State Medical Society.

Among statewide MSOs, the Illinois Medical PSO will be unique in that it will be the only physician-owned, centralized information source in the state that physicians can turn to for the kind of help they need to succeed in a managed care marketplace, according to

John Ray, interim chief operating officer of the Illinois Medical PSO. Unlike some non-physician-operated MSOs, the Illinois Medical PSO will tailor its services to the specific needs of each physician client.

To help ensure that physicians will always lead the Illinois Medical PSO, only individuals who are either licensed to practice medicine in the state or have voluntarily surrendered their license to practice medicine are eligible to buy the stock, which is priced at \$1,000 per share. Investors

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cases rise in
Chicago suburbs

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Risk management society honors ISMS vice president

[CHICAGO] The American Society for Healthcare Risk Management will award its 1996 Distinguished Service Award to Audrey Vanagunas, ISMS' vice president of risk management, education and licensure, according to ASHRM. The award represents the highest honor given to an individual and is based on outstanding performance, national recognition and enhancement of the field of health care risk management. It will be presented at ASHRM's Annual Con-

ference Oct. 3 in San Francisco. Vanagunas has worked in risk management services for the Illinois State Medical Inter-Insurance Exchange since 1991. She works with the ISMIE Risk Management Committee to implement risk management services for ISMIE policyholders. Those services include conducting seminars and developing pamphlets, brochures and audiovisual resources. Named a diplomate of ASHRM in 1990, Vanagunas served as its president in 1989 and as a member of its Executive Board from 1984 to 1990. She has been a member of ASHRM since it was founded in 1979.

ASHRM, a professional society of the American Hospital Association, is committed to the advancement of sound risk management practices. It serves 3,000 members with educational opportunities, research and publications from its Chicago offices. ■

Two Southern Illinois hospitals combine services

[MOUNT VERNON] A joint operating agreement signed during the summer by Good Samaritan Regional Health Center in Mount Vernon and St. Mary's Hospital in Centralia will allow the two hospitals to work on improving access to health care services for Southern Illinois residents, according to a news release from the hospitals. "We have a common vision of how health care services should be provided in the future," said Sister Clarette Stryzewski, president and chief executive officer of Chicago-based Felician Health Care Inc., which operates St. Mary's Hospital. "This new relationship will open new opportunities to expand and enhance services to the communities we serve." The joint operating agreement is not a merger but will allow the hospitals to plan together, create a single budget and provide integrated services for more than 300,000 people. Under the agreement, Good Samaritan will remain a member of the St. Louis Health Care Network, and St. Mary's Hospital will remain a member of Felician Health Care Inc.

A 12-member governance committee will jointly direct the two hospitals. Felician Health Care Inc. and St. Louis Health Care Network each will name three representatives, one community representative from its service area, one physician representative from its medical staff and the president of its hospital. "By joining our organizations into one comprehensive delivery network and working as partners with our physicians, we will be able to offer a full range of high-quality, cost-effective services to better serve our communities," said James McDowell, president of St. Mary's Hospital. ■

Time is running out to renew your license

Physicians who fail to renew their medical licenses in October will face serious consequences. The 90-day grace period expires at the end of the month, and any physician who does not have a new three-year medical license at that time will be practicing medicine without a license. Possible penalties include fines and disciplinary action by the state Medical Disciplinary Board. In addition, physicians could lose their medical liability coverage. Most medical malpractice insurers, including ISMIE, lapse coverage for the time physicians practice without a valid license. To avoid these repercussions, physicians who have not renewed their license must immediately send their completed renewal forms, along with full payment, to the Illinois Department of Professional Regulation. For physicians renewing now, a \$100 late fee applies. The cost of a standard three-year, in-state renewal, including the late fee, is \$400; out-of-state renewals are now \$700 with the late fee. If physicians misplaced their renewal packet or never received one, they may contact the department at (217) 782-0458 to request forms. Doctors should allow ample time for mailing and processing. ■

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Description: Yohimbine is a 3α-15α-20β-17α-hydroxy Yohimbine-16α-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by β-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however, no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patients sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

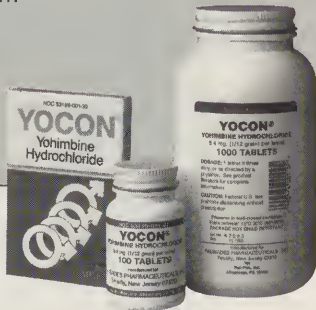
Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral α-adrenergic blockade. These include anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after par-enteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence:^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage is to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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- References:**
1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
 2. Goodman, Gilman — The Pharmacological Basis of Therapeutics 6th ed., p. 176-188. McMillan.
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Top 10 nonfatal occupational injuries and illnesses

Ranking	Injury/illness	No. of incidents
1	Sprains, strains, tears	963,496
2	Bruises, contusions	211,952
3	Nonspecified injuries and disorders (e.g., crushing injuries, hurt back, other pains)	187,082
4	Cuts, lacerations	164,608
5	Fractures	138,545
6	Disorders of the peripheral nervous system (e.g., carpal tunnel syndrome, inflammatory and toxic neuropathy, toxic polyneuropathy)	40,966
7	Rheumatism, other than back (e.g., tendinitis, cystic tumor, bursitis, synovitis, myositis)	40,954
8	Burns, scalds	37,309
9	Foreign bodies; superficial splinters and chips	37,142
10	Hernia (including inguinal, hiatal and ventral)	33,078

Source: Data compiled by the American College of Occupational and Environmental Medicine; 1994 statistics provided by Bureau of Labor Statistics, U.S. Department of Labor

Whooping cough cases rise in Chicago suburbs

PUBLIC HEALTH: NIH official says peaks may be part of three-year cycle. BY DEBORAH PREISER

[CHICAGO] An outbreak of pertussis, or whooping cough, began in the Chicago suburbs in August, with 10 confirmed and seven suspected cases. By the end of the first week in September, another confirmed case and six more suspected cases had surfaced. "To see more than one or two cases in a month is unusual, so to see 10 confirmed cases in less than a month concerns us," said Stephanie Smith, MD, director of communicable disease control for the Cook County Department of Public Health and co-chairman of the Chicago Area Immunization Campaign. To help put the 1996 figures in perspective, 1995 figures show only 15 confirmed cases reported in suburban Cook County.

David L. Klein, MD, bacterial respiratory diseases program officer at the National Institutes of Health, said indicators are that pertussis may be on the rise in other parts of the country as well. "Pertussis is a cyclic disease that reaches peak levels every three to four years. This last peak was in 1993. I would expect to see a wave of new cases at the end of this year or next year."

Dr. Klein said that part of the problem might be unprotected adults. "Even with the DPT shots, a child's protection only lasts about 10 years. There are a lot of unprotected adults in this country. Because the symptoms of the disease are so much milder in adults, [adults] can unwittingly expose many others, including their own children."

In fact, three members of the same family — two young children and a 36-year-old — were among the four confirmed cases reported Aug. 14-27, causing health officials to suspect the transmission may have been from the adult to the children, Dr. Smith said. "In the adult population, the symptoms can be like a cold. Many times people do not seek medical attention, or physicians do not consider pertussis in their diagnosis."

INFANTS UNDER 12 MONTHS are especially at risk. From Aug. 6-13, five cases were confirmed in infants under 10 months, and the public health department quickly issued a warning to physicians and parents to be alert for symptoms, especially in young children, Dr. Smith said. All five infants were up-to-date on their immunizations, she said, but since they hadn't undergone the whole series, they didn't have full immunity. Those immunizations are usually given at 2, 4, 6 and 15 months and then between 4 and 6 years. The health department said it encourages physicians to consider pertussis if a patient has a deep cough lasting longer than two weeks. Close contacts to a person with pertussis should receive prophylactic antibiotic treatment, and children who are behind on their immunizations should be vaccinated.

Although immunizations have made pertussis relatively rare in the United States, about 50 million people contract pertussis worldwide each year, according to Dr. Klein. In June, he organized the NIH Pertussis Conference in Washington, D.C., which brought together 250 physicians and health care professionals from 25 countries to discuss a

spectrum of pertussis issues, including whether adults should be given booster vaccinations.

In the coming year, NIH will conduct a nationwide efficacy study of pertussis vaccinations on adults at six vaccine and treatment evaluation units across the country, Dr. Klein said. "We'll be looking for two things: One, is the vaccine

safe when given to adults? And two, does it reduce the spread of the disease to others, particularly young children who are most susceptible?"

Despite the number of cases that emerged in the Chicago suburbs in August, neither the city of Chicago nor state public health officials report any increases from last year. In fact, through August, fewer pertussis cases had been diagnosed in Chicago this year than during the first eight months of 1995. Nationwide, the number of confirmed pertussis cases through August had risen to 2,849 from 2,608 in 1995, reported the U.S. Centers for Disease Control and

Prevention.

"Immunization levels are generally good around the state, but there are times when outbreaks happen," said Illinois Department of Public Health spokesperson Tom Schaeffer. "Given the contagious nature of the disease, it can infect a lot of people quickly. For instance, we had 36 suspected cases of whooping cough within the Amish community in Whiteside and Bureau counties during the first quarter of this year. This outbreak was traced back to one person traveling outside the community to another event and bringing it back." ■



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REPORT for Illinois Physicians

"Why didn't Blue Cross Blue Shield pay my patient's claim? I used cutting edge technology. I read about it in this week's journal," or "I got paid for treating other patients with the same technology."

Where do our medical policies come from? How are they validated?

The American Medical Association's council on Scientific Affairs states that, "Those who support a new test, procedure or treatment must prove by appropriate peer reviewed controlled trials that such tests, procedure or treatment is effective for the purposes for which it is used and that the burden should not be shifted to opponents to prove a new test procedure or therapy is invalid."

How does Blue Cross Blue Shield of Illinois (BCBSI) determine that a new technology, procedure, or device has reached a state of proven effectiveness as described by the council and how does BCBSI convey that information to all it's employees so that there is uniformity in claim adjudication, based on sound scientific evidence?

BCBSI is a subscriber to or surveys on a regular basis the policy statements or position papers provided by many of the National Technology Review Organizations including:

- The Agency for Health Care Policy and Research
- The American Medical Association's Diagnostic and Therapeutic Technology Assessment
- The Blue Cross Blue Shield Association Technology Evaluation Center
- The National Institutes of Health Policy Statements and Consensus Conferences
- Policy Statements from national Medical Specialty Colleges

In depth review articles from the peer reviewed journals also serve as sources of information.

For information to reach such a level of significance, considerable clinical experience must be achieved. It is just prior to reaching this level of experience that the practicing physician may experience the situation noted in the first paragraph. While BCBSI has an obligation to its covered groups to provide benefits only for "Medically Necessary" services, BCBSI also realizes it's obligation to Illinois physicians to permit access to quality care for their patients who are BCBSI members.

Medical research, necessary to continued progress and excellence, is important to every citizen and provider. It cannot be funded, however, by private insurance alone. Public and private payors, providers, and American citizens-at-large must share in our commitment to continued progress. Premium dollars are adjusted annually to reflect anticipated costs of known and soon-to-be validated clinical interventions, based on the above process.

We continue to evaluate the most efficient methods of transferring information from the medical literature to you and the claim examiner. It is hoped that this brief review will help practicing physicians understand why the scenario in the first paragraph may occur from time to time. Please be prepared to provide the type of peer reviewed documentation needed to resolve the issue if you should experience the situations outlined above. This will allow both of us to continue to provide quality care to your patients and our members.

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EDITORIAL

Direct hits at violence

A patient saw her family physician twice in two weeks complaining of left-sided chest pain, tremors, vomiting and headaches. After a medical workup, she was referred to a mental health center, where she was diagnosed as having adjustment disorder with depressed mood. A week later, she returned with left arm numbness, difficulty concentrating and loss of appetite. She happened to mention that lately there had been some arguments at home. Direct questioning revealed she was being battered.

This true story represents just one of the many opportunities that physicians have to diagnose domestic violence. As many as 35 percent of women who visit emergency departments are there because of symptoms related to ongoing abuse, according to the U.S. Department of Health and Human Services. But of the patients injured by domestic violence, less than 10 percent of those who show up at the emergency department are identified as having been battered, according to the Family Violence Prevention Fund. That statistic was one of the reasons behind a training session held Sept. 12-13 in Chicago for emergency department teams from 12 hospitals across the state. The conference – conducted by the office of Illinois Attorney General Jim Ryan and co-sponsored by ISMS and the Chicago Department of Public Health – provided strategies for the screening and treatment of victims.

The conference is only one segment in

Ryan's three-part plan to fight domestic violence statewide. In addition, he'll propose a new law that would make it a crime for offenders to interfere with the ability of victims to report domestic violence, and his office will provide 400 law enforcement agencies with camera kits to document crime scenes and injuries.

During the next month, several anti-violence programs will be held across the state. As this issue went to press, the ISMS Alliance was conducting its fall conference to kick off a statewide billboard campaign focused on the problem of violence against children.

ISMS is co-sponsoring a violence prevention conference to be conducted Oct. 4-5 in Chicago by the Illinois Council for the Prevention of Violence. This conference will discuss the roots of different forms of violence and prevention.

Several ISMS members will also participate in a program to be held Oct. 30-Nov. 1 in Oak Brook. Co-sponsored by the AMA, the American Bar Association, HHS and the U.S. Department of Justice, the program will explore ways to coordinate a response to family violence.

Eighty percent of Americans say they could tell their physician if they were victims or perpetrators of family violence, according to the AMA. We need to encourage victims to speak up. This fall, medical organizations and agencies are giving domestic violence the attention it deserves. Let's make a personal commitment to do the same.

PRESIDENT'S LETTER

Women in medicine

Sandra F. Olson, MD



If the current trend continues, one-third of the physician work force will be women in 2010.

September has been designated as Women in Medicine Month by the American Medical Association to emphasize the increasing role of women in our profession. Not only do women physicians continue to grow in number, but their influence and power are extending also, albeit not in the same proportion.

Women physicians now comprise 20 percent of all doctors in the United States, up from just 10 percent in 1970. More than 40 percent of medical students are female. If the current trend continues, one-third of the physician work force will be women in 2010. Female physicians are still less represented in the higher-paying specialties and overall work fewer hours and see fewer patients than their male counterparts. By and large these appear to be preferences based on personal choice, mainly because of domestic responsibilities. There are still barriers for women in some medical fields, while in others, such as Obstetrics/Gynecology, women are more sought after than their male counterparts when they finish their residency and look for practice opportunities.

A recent survey by Laurence C. Baker, PhD, showed that young physicians, both male and female, in equal practice settings with the same number of hours worked earn equal pay. There continue to be discrepancies in older physicians and certain specialties, especially the higher-paying ones. Women do not fare as well in the research settings; they generally receive less funding and space than men.

There is no question, however, that women in these situations will likely never achieve parity with men. They simply don't have the time. Additional responsibilities are a third job for a great proportion of women physicians, especially in the younger age group. They find themselves balancing the roles of doctor, wife and mother,

each of which requires significant energy and time and may be considered a full-time occupation. There often just isn't enough energy left for other activities until later in the woman's career, and then it may be too late to devote the hours necessary to move up the ladder.

Women are participating in organized medicine in greater numbers. They are the fastest-growing group in the membership of the American Medical Association, and their presence doubled in the House of Delegates between 1989 and 1994. That trend is duplicated in my specialty society, the American Academy of Neurology. At ISMS, 18 percent of members are female, up from 14 percent in 1987.

Women still lag behind their male counterparts in leadership, but that status is changing as more women physicians aspire to academic, administrative and political positions. The pipeline is expanding as time increases the pool. More women are achieving professorial rank and being tapped for department chairmanships and in deanships. For example, Janis Orlowski, MD, who serves on the ISMS Board of Trustees, presently also serves as the executive associate dean at Rush Medical School. Many state and local medical societies have had or are electing a woman president, and a woman will likely become president of the American Medical Association soon.

It is interesting that the gender image in medicine is changing slowly but surely. As a woman physician, I feel little if any discrimination in my field or at my institution – and certainly not from you, the members. You have extended yourselves with warmth and hospitality as I travel around our state. I am proud to be here, not primarily because I am a woman physician, but because of the trust and faith you have placed in me by electing me as your president. I know you will continue to show the same courtesies next year to Dr. Jane Jackman.

GUEST EDITORIAL

Do we really care about kids who light up?

By Leonard Jason, PhD

Copyright 1996, Leonard Jason

For every 100 teen-age girls who attempt to buy a pack of cigarettes illegally in Chicago, only one will be turned away. For every 100 boys, 17 will be denied. The sad fact is that the vast majority of stores in Chicago sell cigarettes to kids and set them up not only for chronic health problems but on a path that often leads to alcohol and narcotic use.

Mayor Richard M. Daley and Ald. Edward Burke (14th) recently proposed an ordinance aimed at curbing unlawful cigarette sales to youth in Chicago, and President Clinton is prepared to enact an executive order designed to stem illegal sales nationally.

These are great first steps, but to achieve a true reduction in teen smoking we must price cigarettes out of reach for teens by raising the excise tax, reduce their appeal by banning advertising completely and fully implement the Synar Amendment, which holds states accountable for a measurable reduction in illegal cigarette sales. Chicago's pro-

gram consists of a merchant education initiative to remind retailers of the law, an increase from \$200 to \$500 in fines against stores that sell cigarettes to kids, with license suspensions for stores caught in violation three times, and an enforcement program to test whether merchants are complying.

If executed carefully, Chicago could be the first major metropolitan area to enact such a program. But its success depends on the city's commitment to the enforcement component.

Our research team at DePaul University has been sending minors randomly into stores to purchase cigarettes, so-called stings, in Chicago for several years. We found alarming rates of violation. Every gas station we visited sold to underage kids. In addition, 94 percent of convenience stores, 78 percent of grocery stores, 72 percent of mom-and-pop stores and 61 percent of pharmacies sold to our 16- and 17-year-old testers.

The mayor and Ald. Burke should be commended for bringing this issue back to the forefront, but they must also be aware of the realities of their program.

Our research determined that sales rates were unaffected when warning signs were posted in stores.

Additionally, even when merchants asked for age identification, they still sold to minors 33 percent of the time. When we provided merchants with training on the law, illegal sales of cigarettes decreased for a few months but returned shortly to unacceptable levels.

The mayor has argued for continued merchant education programs, which are supported by the tobacco industry, the Illinois Liquor Control Commission and the Illinois Retail Merchants Association. It's not surprising that such groups advocate for education programs because they offer few negative consequences for businesses that sell cigarettes to minors. When combined with enforcement programs, these initiatives can be valuable, but if offered in and of themselves, these programs support only the vested interests of the status quo and not the best interests of our youth.

Thus, the key to permanently reducing cigarette sales to kids is a consistent enforcement program in the same stores. Using this method, teams that were able to buy cigarettes 85 percent of the time at the beginning of the study could buy them only 20 percent of the time after the study. Simply put, merchants got tired of paying fines and knew that if they continued to sell they would be caught.

Daley is also toying with the idea that youths who purchase cigarettes should be held responsible for their actions. The

practicality of the police being called to an illegal buy is unwieldy and unwise. Several years ago, the Metropolitan Lung Association of Chicago worked with Ald. Burke's office to draft an ordinance that made the sale of cigarettes an administrative rather than a criminal activity. The old system required that a police officer witness an illegal cigarette purchase. As a consequence, no tickets were given out for years in Chicago for underage sales of cigarettes.

Now that the process has been changed, once a minor is sold cigarettes, a member of the Department of Revenue can issue a ticket. Tickets and regular feedback to merchants will significantly reduce the percentage of retailers who sell minors cigarettes. We know this strategy works. Now the question is whether this approach will be expanded to all stores in Chicago.

Only if all stores are brought into this program and the program is enforced at least every four months will we make a dent in this problem.

The economics support these approaches because fines and license fees pay for themselves. The question is whether our leaders have the courage and heart to enact the most potent and proven methods of attacking our youth's most deadly foe. There are powerful economic and political forces that will continue to thwart what needs to be done. With boldness, with decisiveness, with vision, our politicians can become statesmen, and in the process our youth can be protected.

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Edgar acts on
ISMS-backed bills

PAGE 12

ISMIE Update

For whom the statute tolls

By Diane Cernivivo, JD, and Samir M. Jariwala

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Imagine a 30-year-old man suing your hospital for negligence that occurred when he was born. He claims birth injuries that were so severe, they could cost the hospital millions of dollars in damages. Imagine just how difficult it would be to have to defend this claim after such a long time. Today in Illinois, you may not just have to imagine this; you may have to defend it. In March of 1995, an Illinois appellate court examined the statute of limitations for a catastrophic birth injury and came to a startling conclusion – there is no limitations period.

In Illinois, there is a specific statute of limitations for medical malpractice actions, Section 13-212. The statute has been amended numerous times, shortening the outer limits in which a suit may be filed or enlarging the classes of persons to whom the statute applies. The latest amendment in 1987 created Subsection (b), relating to minors, and shortened the time within which suits on a minor's behalf could be filed. The relevant language in the subsection reads: "No action for damages for injury or death against any physician, dentist, registered nurse or hospital, whether based upon tort, or breach of contract, or otherwise arising out of patient care shall be brought more than eight years after the date on which occurred the act or omission or occurrence alleged."

This amendment shortened the statute of limitations for minors from 18 years plus two years (i.e., the age of majority plus two years) to no more than eight years. The purpose of this amendment was to limit the long tail of liability that hospitals and physicians faced for alleged malpractice involving a minor – up to 20 years

for a birth injury. With the amendment, it was thought that hospitals and physicians would be better able to defend a claim by a minor brought within eight years, while facts and witnesses are still available. The very purpose of a statute of limitations or time within which to sue is to avoid having to defend stale claims.

Subsection (c) of the medical malpractice limitations statute related to legally disabled persons. This provision was not amended in 1987. It reads as follows: "If the person entitled to bring an action described in this section is, at the time the cause of action accrued, under a legal disability other than being under the age of 18 years, then the period of limitations does not begin to run until the disability is removed."

In practice, it had been thought that regardless of the allegation of brain damage or mental retardation as being caused by the malpractice, the statute of limitations for a minor was eight years as provided in Subsection (b) of the statute. However, in *Clark vs. Han*, the appellate court decided that there is no tolling of the limitations period of a brain-damaged infant. The court relied on Subsection (c), which states that the period of limitations does not begin to run until the disability is removed. As a result, a case could be brought at any time, since mental retardation is a legal disability, and the period of limitations does not begin to run until the disability is removed, which will not happen. This decision exposes hospitals and physi-

cians to an unlimited statute of limitations period for cases involving brain damage or mental retardation. As noted by the Clark court, "If the disability is never removed, as in the present case, then the limitations period would never begin and, in turn, never end."

In *Clark*, the trial court dismissed the lawsuit as being barred by the limitations period. The lawsuit alleging a birth injury to Scott Clark was not filed until 16 years later. The appellate court reversed the dismissal. The court decided that Subsection (c) for legal disabilities rather than Subsection (b) for minority applied in cases where both conditions existed. Thus, the claim was effectively tolled indefinitely.

The trial court dismissed the case at the pleading stage. The extent of the minor plaintiff's

mental retardation was not at issue. The complaint stated that "Scott Clark is and has been since birth severely mentally retarded, unable to speak or otherwise communicate, unable to control his voluntary muscles, unable to control his bodily functions and unable to feed or care of himself. Plaintiff Scott Clark is entirely without understanding or capacity to make or communicate decisions regarding his person and totally unable to manage his estate or financial affairs, is unable to handle the ordinary affairs of life and is permanently and totally disabled from [date of birth] until the present time." At the pleading stage, the court had to assume this allegation was true.

The minor plaintiff had never been legally pronounced incompetent or disabled by a court. Nonetheless, upon appellate

review, the Clark court found that Subsection (c) for legally disabled people controlled.

As a final comment, the court noted, "If the legislature had wanted to treat legally disabled minors in the same manner as all other minors, it could have easily done so. This court does not operate as a third house of the legislature to cure or codify, by judicial action, defendants' conception of what the legislature allegedly meant to do." Rehearing was denied. The Illinois Supreme Court rejected a petition to appeal in November 1995.

In reaching its decision, the Clark court analyzed a federal case, *West vs. Rockford Memorial Hospital*. In *West*, since the term "legally disabled" is not defined in Section 13-212, the defense suggested the court should look to other statutes for

MALPRACTICE ROUNDUP

Plaintiff must prove value of lost chance of survival

The Supreme Court of Louisiana held that when a plaintiff seeks damages for the loss of a less-than-even chance of survival because of the negligent treatment of a pre-existing condition, the value of that lost chance must be proved, according to the Aug. 5 edition of the National Law Journal.

In *Smith vs. State* the plaintiff filed a suit against the Louisiana Department of Health and Hospitals for the death of her husband. She alleged that the state, which admitted it was negligent, failed to treat her husband for cancer after an X-ray pointed to the disease. The trial court ruled that the plaintiff had not met the burden of proving that the 15-month delay in treatment caused her husband to die or lose his chances of survival. The court relied on information that the husband lived without treatment as long as someone who had received treatment could have expected to live.

The Supreme Court held that the plaintiff must prove, by a preponderance of evidence, that the victim had a chance of survival when the negligence occurred and that the actions taken had deprived the person of part or all of that chance. Further, the court found that the only damages in such cases are the value of the lost chance. ■

Physician doesn't have duty to third party

The Court of Appeals of Indiana ruled that a physician who vaccinated and immunized a patient had no obligation to a third party who was injured in a traffic accident after the patient lost consciousness and collided with the third party's car. The patient had been driving home from the physician's office, where he lost consciousness twice, according to the June issue of Medical Liability Advisory Service.

The court found there was no special relationship between the physician and the third party and there was no cause-and-effect relationship between the vaccinations and the traffic accident that could have reasonably been foreseen. In addition, the public health benefits related to vaccination and immunization outweigh the risk of harm to third parties, the court said.

The appeals court affirmed a circuit court's ruling for the doctor. ■

a definition of legally disabled when no formal adjudication of disability occurred. "Defendant contends that such an interpretation of 13-212 [not requiring an adjudication of legal disability] will subject the medical profession to the risk of lawsuits until the death of the patient. This may be so. However, an individual should not be deprived of this substantive right to sue because his guardian did not have him adjudicated 'legally disabled.'" The West court acknowledged that its rationale was contrary to Illinois public policy to limit medical malpractice suits.

Until the Illinois Supreme Court or the state legislature addresses the issue of concurrent disability, hospitals, medical practitioners and their insuring organizations must be aware that these types of cases may be filed at any time. Indeed, many plaintiffs' attorneys who once rejected such lawsuits, believing that the statute of limitations had expired, are now resurrecting these files.

Since no guidelines exist as to the degree of disability that is necessary to invoke Subsection (c), many questions arise: Is there a minimum as to how much disability is enough to toll the limitations period? Is merely alleging mental retardation sufficient to toll the limitations; what proof is needed? Is a learning deficit sufficient to toll the limitations period? Is a physical handicap that severely impairs a minor sufficient to toll the statute? Is a low IQ enough to qualify for such a disability? For now, there are no answers.

Be aware, the disability does not have to result from the malpractice in order to invoke Subsection (c). A potential for abuse will exist until the Supreme Court or the legislature determines what constitutes a legal disability without a formal adjudication for incompetency. Although the complaint's allegations must be accepted as true at a pleading stage, the issue of legal disability will become a fact subject to discovery. Ultimately the trial court will need to determine the timeliness of the lawsuit.

Other states' statutes present some rational solutions to this dilemma. What may be necessary in Illinois to correct this conundrum is a statutory amendment that limits the time one has to file on behalf of a legally disabled person.

Some states, regardless of minority or incompetency, have an outer limit within which suit must be brought regardless of whether the disability is removed. The outer parameter of the statute of limitation for birth injuries involving brain damage is five years in South Dakota, six years in Idaho, seven years in Oklahoma, eight years in Kansas, 10 years of age in Nevada and 20 years in West Virginia. In California there is no tolling if the suit is filed by a guardian ad litem for an incompetent child.

This brief survey of other states' statutes demonstrates that an outer parameter can be imposed even during the period of disability. Perhaps the Illinois state legislature should amend the statute either by defining a statute of limitation in those instances in which there is a concurrent disability (e.g., minority and mental retardation) or by creating an outer parameter for those instances of legal disability. With either option, the long tail of liability would be addressed. If the legislature does this, medical professionals and organizations need not defend stale claims, thus preventing indefinite exposure to liability for the

most catastrophic injuries of alleged brain damage at birth, which has seemingly been created by the Clark decision.

Until the Illinois Supreme Court addresses this issue, or there is a legislative amendment, hospitals, the medical profession and insurers once again face the specter of the unlimited long tail of liability in Illinois.

Until this dilemma can be addressed, risk managers and in-house legal counsel must safeguard their institutions. Systems to reinforce and review within your facility include:

- Strengthen occurrence reporting systems for difficult deliveries or low Apgar

infants.

- Explore the potential for the value of an occurrence indicator requiring the reporting of all mentally and physically disabled children delivered at your institution and subsequently seen in the emergency department, ambulatory care setting or pediatric unit. This would permit risk management an opportunity to explore a birth injury case if not identified during the delivery admission.

- Aggressively investigate birth injury-related incidents. Investigations take on greater importance particularly when faced with the dimming of staff's memories compounded by the passage of time.

- Reinforce systems for the preservation of the medical record, fetal monitor strips and other testing (lab, radiology, etc.).

- Maintain human resource files for employees who have completed their training (residents, technicians, etc.) or staff who have left hospital employment to ensure locating them at a later point in time.

As with all incident investigations, consult outside legal counsel to ensure that written documentation of your investigation is afforded the best protection from discovery. Record and file maintenance takes on greater importance in light of this open-ended statute. ■

If you're like most physicians, you want to steer clear of the business pressures that come with operating your own medical practice and concentrate on caring for your patients—and a little more time for your personal life.

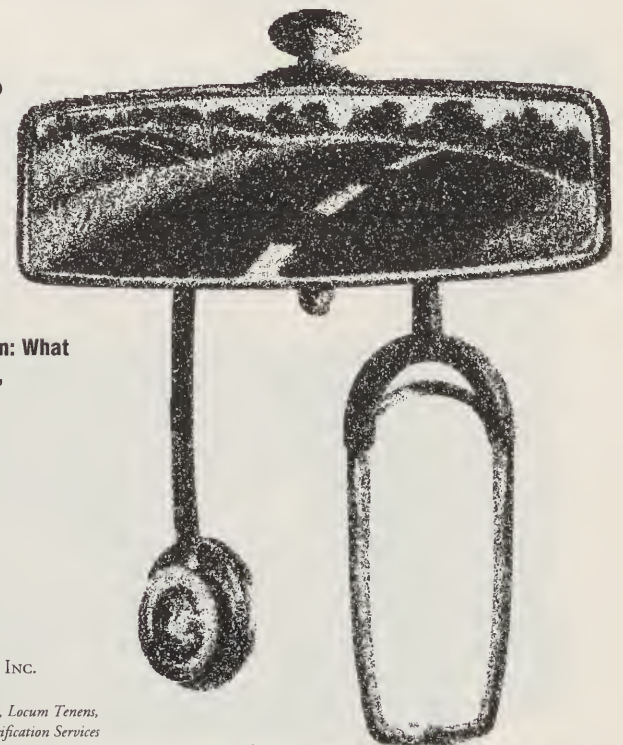
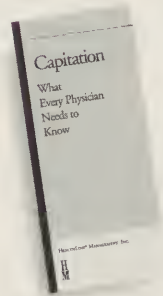
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Chicago hosts Democratic

BY JANICE

EMS staff prepares for worst, faces best

Staff members of the Chicago Fire Department Emergency Medical Services field hospital spent the week of the Democratic National Convention in readiness for an emergency they hoped wouldn't happen. After setting up their field hospital inside the Wilma Rudolph Learning Center at 110 N. Paulina, northwest of the United Center, physicians, nurses, paramedics and firefighters settled in for the four-day convention.

"In the event of a disaster, mass casualty or other incident, we'd be activated. We're set up to handle multiple victims inside, with tents outside for any overflow," said Paula Willoughby, MD, EMS medical director for the Chicago Fire Department and an emergency physician at West Suburban Hospital Medical Center in Oak Park.

Illinois Medicine interviewed EMS participants while the convention was in progress, but when it concluded, 35,000 people had streamed through or around the United Center. "Chicago is very used to mass gatherings, and the EMS is comfortable and familiar with responding to them, so from the standpoint of size, this is not new," Dr. Willoughby said.

With two doctors, four nurses, eight paramedics and 10 firefighters standing by at all times, the field hospital was equipped to handle 200 patients. The physicians and nurses, all volunteers from Chicago-area hospitals, worked three shifts for round-the-clock coverage. "With the assistance of medical personnel, we're more than capable of handling the number of patients we are projected to handle," said Cesar Blanco, deputy chief paramedic for the Chicago Fire Department and commanding officer for the support and logistics division of the EMS.

On a tour of the field hospital, Dr. Willoughby explained the arrangements for patient care. Patients would arrive by ambulance, by a specially adapted golf cart or on foot. Some would be triaged at the site of their injuries, and others inside the hospital. All individuals would receive red, yellow or green tags based on the seriousness of their injuries. The most critically injured would receive red tags and be sent to the red room.



Andrew Corrigan Halpern

Taking patient Troy Brown's blood pressure during the convention is Patt Perlman, RN, co-owner of Custom Prehospital Services, which provides medical services at all United Center events.

The red room was set up to treat four victims, but the space could accommodate the simultaneous treatment of 10 to 12 patients. Standing by were mobile carts equipped with the supplies needed for initial and immediate intervention, including airway-intervention instruments, IV and suction equipment, drugs, a monitor and a defibrillator. Protective equipment for the staff was stored nearby.

The yellow room awaited patients with less severe head injuries or broken bones. Those with cuts, sprains or other minor injuries would await treatment on folding chairs set up in the green room.

Depending on the scale of the emergency and the number of victims, the first wave of patients would have been hospitalized in the immediate area at Cook County Hospital, Rush-Presbyterian-St. Luke's Medical Center or the University of Illinois Hospital and Clinics.

"The degree of coordination of these services is quite impressive," said volunteer David Thompson, MD, an emergency physician at MacNeal Hospital in Berwyn.

Fortunately, the problems faced by the EMS staff were all minor. They treated some police officers for minor injuries sustained during the convention setup, a Secret Service agent for an eye problem and several children for scrapes and bruises.

Despite the fact that they didn't confront any crises, the staff found working at the field hospital a learning experience. "Most hospital personnel are less familiar with hazardous materials situations so we wanted to make sure they were up to speed," Dr. Willoughby said. So a pharmacist from the Department of Veterans Affairs Edward Hines Jr. Hospital gave a presentation on how to handle an emergency stemming from hazardous materials. The staff learned

(Continued on page 11)



Andrew Corrigan Halpern

Fire department paramedics Joe Keneipp (left) and Pat Ward stand ready for action.

dic National Convention

OR SENBERG

A physician's perspective on the convention

Physicians are increasingly assuming the role of patient advocate, and many have found that getting involved in politics is the best way to make their patients' needs known in Springfield and Washington, D.C. One such doctor is Jim Turner, DO, a family physician in Marshall, who attended the Democratic National Convention in Chicago last month.

"We close the door and talk to our patients, so we know what they need," said Dr. Turner, who is a member of ISMS' Governmental Affairs Council. "We have to get involved and help guide politicians, open that line of communication so that hopefully we can relay those needs and eventually get them answered with a policy or a bill in Congress."

Dr. Turner spent two evenings at the convention. On his first night he joined the Illinois delegation on the main floor at the United Center. He said he listened to Hillary Clinton's speech and talked to U.S. Rep. Richard Durbin (20th District), U.S. Sens. Paul Simon and Carol Moseley-Braun of Chicago, and Illinois Sen. Penny Severns. Dr. Turner said Severns is a longtime friend from Decatur, where he worked as a paramedic for five years after college and served on the city council.

Hillary Clinton's reference that it takes a village to raise a child caused Dr. Turner to think of his own "village" of Marshall with its 3,500 residents and one stoplight, he said. "Marshall is the kind of place where the barber compliments a teen-ager on his performance at the football game the night before," he said. "That gives kids self-esteem. Parents can't do it all. There are things a community can do that are very helpful." Dr. Turner said that he tries to further that community spirit by inviting high school seniors to spend a day observing him practicing medicine, speaking at schools, making house calls and serving as team doctor at the high school.

During the second night of the convention, Dr. Turner said he sat high up in the stadium sharing the crowd's enthusiasm and listening to speeches expressing the convention's "well-organized, strong themes." Vice President Al Gore's speech, in particular, made an impression on Dr. Turner. "What Gore said about the tobacco industry and how they target teens is exactly right. You see [targeted ads] on billboards, at athletic events. When kids go to athletic events, they see athletes who have trained and worked out, but on the goal post is a [cigarette] ad." He added that such situations give double messages to young people.

Dr. Turner said he has seen the harmful effects of smoking in his own practice: "When flu season hits, people who are smokers end up in the hospital. The No. 1 diagnosis in our hospital for length of stay is chronic obstructive lung disease, emphysema. And I always worry about smokers when they're going to have surgery."

In attending the convention, Dr. Turner followed in the footsteps of his father, who attended 30 national conventions. In fact, Dr. Turner said his interest in national politics began when he accompanied his

father to the 1980 Democratic convention in New York City. "I enjoyed the experience," he said, adding that when he learned the Democrats would be coming to Chicago, he was determined to take part in the event. "With my schedule and three young sons, I couldn't devote the time it would take to run as a delegate." But he was able to get credentials to attend from U.S. Rep. Glenn Poshard (19th District), he explained.

Regarding the Clinton administration's health care reform proposal, Dr. Turner said he was actively interested and even went to Washington with the American Hospital Association and met Ira Magaziner. "The Clinton plan didn't work out because when they started trying to put everybody under one big tent, it just got too complicated. But it definitely started the health care debate."

Dr. Turner said he doesn't expect a new health care plan from Washington if the president is re-elected. "I think they're going to let the health care industry find its own way. But at the same time, I believe the government needs to find a way to cover the average working person, the person the Democrats talked about so much at their convention."

Dr. Turner stressed the need for physicians to get involved politically by contributing to a campaign, attending a debate or joining a city council or school board. Most important, physicians should get to know their state and federal legislators. "Don't just read what's in the newspaper. Go listen to someone. Follow him or her around. Get to know [legislators] and let them get to know you."

Once physicians have created those lines of communication, they should call their legislators about pending legislation that affects them and their patients. Eventual-

(Continued on page 11)



John McNulty

Enjoying a bird's-eye view of the convention floor, Jim Turner, DO, a family physician from Marshall, prepares to hear first lady Hillary Clinton's speech Aug. 27.



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We're part of the cure.

EMS staff prepares

(Continued from page 8)

how to decontaminate patients and how to treat themselves with antidotes to organophosphates and cyanide.

The field hospital was not the only place where medical services were available. Inside the United Center, four two-person teams of fire department paramedics made their rounds. Each team was equipped for radio communication and carried initial airway equipment, a first round of drugs, a life pack with defibrillator, protective equipment for the paramedics and a foldout stretcher.

Also inside was Custom Prehospital Services, a Peotone-based company that has a regular contract to provide medical services at all United Center events. The company staffed two first-aid rooms with nurses and paramedics.

Each day of the convention 20 to 30 patients received help from the first-aid stations. Complaints ranged from blisters to light-headedness to chest pain. The most serious cases were sent by ambulance to local hospitals.

"We were very busy," said company co-owner Patt Perlman, RN, project director for emergency medical services at Christ Hospital and Medical Center in

Oak Lawn. "Our first patient was a worker who'd received an electric shock."

Outside the center, paramedics drove two specially adapted golf carts carrying such emergency equipment as C-collars, backboards, drug boxes and monitors. Ambulances were available to pick up patients at the center's exits and carry them to the field hospital.

On a more personal medical note, President Clinton and Vice President Gore had an ambulance following each around town throughout the convention. In a medical emergency, Secret Service officials would have directed EMS staff on where the leaders should have been taken. ■

A physician's

(Continued from page 9)

ly, those legislators may call doctors they know to find out how certain bills might affect patients in their areas.

"Instead of getting only the spin from the medical organizations, legislators will hear from you about what it would mean in your office if they passed a particular law tomorrow," Dr. Turner said. "We need to get enough physicians around the state who communicate with their legislators so that if there's an issue that's important to patients, [physicians] can make a difference." ■

Cook County board approves bond issue to fund new public hospital

[CHICAGO] A bond issue approved by the Cook County Board of Commissioners in July will provide the funds to begin building a new Cook County Hospital. About \$114 million of the total \$250 million loan package will be used for the new hospital while the remaining funds will support other county capital improvements, according to Tom Glaser, chief financial officer of Cook County.

"We would expect to begin in September with some demolition of facilities, which we need to lay the footprint for the new hospital," Glaser said.

The Illinois Health Facilities Planning Board granted a certificate of need for the new hospital in December 1995. The existing 82-year-old building on Chicago's West Side will be razed to make way for the new 464-bed facility, which will be located near the current hospital.

If all goes as planned, the new hospital should open Jan. 1, 2001, said Glaser. The bond deal approved in July should provide enough funds to take the construction project through November 1998, Glaser said. After that, the county may look to another bond issue to complete the project, he added. The total cost is estimated at \$551.7 million. ■

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Edgar acts on ISMS-backed bills

LEGISLATION: Ultimate fighting exhibitions banned; new Good Samaritan Act created. BY JANE ZENTMYER

[SPRINGFIELD] In late summer Gov. Jim Edgar acted on ISMS-supported legislation sent to him during the spring legislative session by the Illinois General Assembly. Those bills included the following:

ULTIMATE FIGHTING EXHIBITIONS

Illinois joined three other states — Kansas, Ohio and South Carolina — as

well as the Chicago City Council in banning ultimate fighting exhibitions when Edgar signed H.B. 3271 into law on July 30. "Ultimate fighting is violent, and it is dangerous to participants," Edgar said. "It has only two rules — no eye-gouging and no biting. Otherwise, it's no-holds-barred street fighting, and we do not need to promote this kind of violence to the youth of Illinois."

Chief sponsors of the measure were Reps. James Meyer (R-Bolingbrook) and Thomas Johnson (R-West Chicago) and Sen. William Peterson (R-Prairie View). The new law is consistent with a position adopted by the ISMS House of Delegates at its Annual Meeting in April.

BLOOD AND URINE COLLECTION

Edgar used his amendatory veto powers Aug. 14 to alter H.B. 1249, an omnibus crime bill that included an ISMS-supported amendment to the driving-while-intoxicated provisions of the Vehicle Code. The amendment would have granted civil immunity to a person who, at a law

enforcement officer's request, withdrew blood or collected urine for evidentiary purposes except for an act performed in a willful and wanton manner.







The governor did not object to the civil immunity provisions but modified portions of the bill related to prison inmates. He said those provisions would be "ripe for promoting further litigation in the unending flow of prison lawsuits." The entire bill, sponsored by Johnson and Sens. Edward Petka (R-Plainfield) and Carl Hawkinson (R-Galesburg), will return for concurrence to the Illinois General Assembly. Lawmakers then have the options to do nothing and let the bill die,

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-  *Elevations of AST and/or ALT, some significant, have been reported in association with diclofenac treatment; cases of severe hepatic reactions have been reported. If patients are treated chronically, periodic monitoring of transaminases is recommended. Please see brief summary of Prescribing Information on last page of this advertisement*



Reference: 1. Data on file, Ciba.

CibaGeneva
PHARMACEUTICALS

accept the bill as law with the governor's changes, or override the veto and turn the bill into law as originally written.

ATHLETES AND DRUGS

Anyone distributing a nonprescribed drug to a person under the age of 18 to stimulate weight gain or loss for athletic competition could be found guilty of drug-induced infliction of aggravated battery to a child athlete, under a new law created when the governor signed H.B. 3617 on Aug. 9. Sponsored by Rep. Anne Zickus (R-Palos Hills) and Sen. Robert Raica (R-LaGrange), the law's final version included an ISMS-proposed

amendment clarifying that the offense does not apply to licensed physicians who distribute such drugs under their usual and customary standards or to retail merchants selling over-the-counter products.

Zickus said she sponsored the bill after a coach gave a 10-year-old Palos Hills boy the diuretic Lasix to help him lose enough weight to participate on a local youth football team. The law



Edgar

reflects the realities of competitive children's sports. "Organized sports for children are supposed to be character-building experiences, not potentially life-threatening ones," she said. "Drugs have no place in children's sports."

REPORTING ALCOHOL AND DRUG LEVELS

H.B. 3613, which the governor signed into law on July 18, gives health care workers the option of reporting to law enforcement agencies the blood alcohol and drug test results of emergency department patients injured in motor vehicle accidents. The reporting does not result in civil liability or professional

discipline except in cases of willful or wanton misconduct. Rep. David Winters (R-Rockford) and Sen. J. Bradley Burzynski (R-Sycamore) sponsored the bill leading to the law, which mirrors policy adopted this year by the ISMS House of Delegates.

GOOD SAMARITAN ACT

Edgar signed H.B. 3618 on Aug. 2 creating the Good Samaritan Act, which consolidates into one act all Good Samaritan provisions in other laws relating to various professions and activities. The bill's sponsors were Winters and Burzynski. ■

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Brief Summary
(For Full Prescribing Information, see Package Insert.)

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Cataflam Immediate-Release Tablets and Voltaren Delayed-Release Tablets are indicated for the acute and chronic treatment of signs and symptoms of osteoarthritis and rheumatoid arthritis. Voltaren-XR Extended-Release Tablets are indicated for chronic therapy of osteoarthritis and rheumatoid arthritis. In addition, Cataflam Immediate-Release Tablets and Voltaren Delayed-Release Tablets are indicated for the treatment of ankylosing spondylitis. Only Cataflam is indicated for the management of pain and primary dysmenorrhea, when prompt pain relief is desired, because it is formulated to provide earlier plasma concentrations of diclofenac (see CLINICAL PHARMACOLOGY, Pharmacokinetics and Clinical Studies).

CONTRAINDICATIONS

Diclofenac in all formulations, Cataflam, Voltaren, and Voltaren-XR, is contraindicated in patients with known hypersensitivity to diclofenac and diclofenac-containing products. Diclofenac should not be given to patients who have experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactoid-like reactions to diclofenac have been reported in such patients (see WARNINGS—Anaphylactoid Reactions, and PRECAUTIONS—Preexisting Asthma).

WARNINGS

Gastrointestinal Effects

Peptic ulceration and gastrointestinal bleeding have been reported in patients receiving diclofenac. Physicians and patients should therefore remain alert for ulceration and bleeding in patients treated chronically with diclofenac even in the absence of previous G.I. tract symptoms. It is recommended that patients be maintained on the lowest dose of diclofenac possible, consistent with achieving a satisfactory therapeutic response.

Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy: Serious gastrointestinal toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAID therapy. Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous G.I. tract symptoms. In patients observed in clinical trials of several months to 2 years' duration, symptomatic upper G.I. ulcers, gross bleeding, or perforation appear to occur in approximately 1% of patients for 3-6 months, and in about 2%-4% of patients treated for 1 year. Physicians should inform patients about the signs and/or symptoms of serious G.I. toxicity and what steps to take if they occur.

Studies to date have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious G.I. events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals, and most spontaneous reports of fatal G.I. events are in this population. Studies to date are inconclusive concerning the relative risk of various NSAIDs in causing such reactions. High doses of any NSAID probably carry a greater risk of these reactions, although controlled clinical trials showing this do not exist in most cases. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of G.I. toxicity.

Hepatic Effects

Elevations of one or more liver tests may occur during diclofenac therapy. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Borderline elevations (i.e., less than 3 times the ULN [=the Upper Limit of the Normal range]), or greater elevations of transaminases occurred in about 15% of diclofenac-treated patients. Of the hepatic enzymes, ALT (SGPT) is the one recommended for the monitoring of liver injury.

In clinical trials, meaningful elevations (i.e., more than 3 times the ULN) of AST (SGOT) (ALT was not measured in all studies) occurred in about 2% of approximately 5700 patients at some time during Voltaren treatment. In a large, open, controlled trial, meaningful elevations of ALT and/or AST occurred in about 4% of 3700 patients treated for 2-6 months, including marked elevations (i.e., more than 8 times the ULN) in about 1% of the 3700 patients. In that open-label study, a higher incidence of borderline (less than 3 times the ULN), moderate (3-8 times the ULN), and marked (>8 times the ULN) elevations of ALT or AST was observed in patients receiving diclofenac when compared to other NSAIDs. Transaminase elevations were seen more frequently in patients with osteoarthritis than in those with rheumatoid arthritis (see ADVERSE REACTIONS).

In addition to enzyme elevations seen in clinical trials, postmarketing surveillance has found rare cases of severe hepatic reactions, including liver necrosis, jaundice, and fulminant fatal hepatitis with and without jaundice. Some of these rare reported cases underwent liver transplantation.

Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac, because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. The optimum times for making the first and subsequent transaminase measurements are not known. In the largest U.S. trial (open-label) that involved 3700 patients monitored first at 8 weeks and 1200 patients monitored again at 24 weeks, almost all meaningful elevations in transaminases were detected before patients became symptomatic. In 42 of the 51 patients in all trials who developed marked transaminase elevations, abnormal tests occurred during the first 2 months of therapy with diclofenac. Postmarketing experience has shown severe hepatic reactions can occur at any time during treatment with diclofenac. Cases of drug-induced hepatotoxicity have been reported in the first month, and in some cases, the first two months of therapy. Based on these experiences, transaminases should be monitored within 4 to 8 weeks after initiating treatment with diclofenac (see PRECAUTIONS—Laboratory Tests). As with other NSAIDs, if abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), diclofenac should be discontinued immediately.

To minimize the possibility that hepatic injury will become severe between transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and "flu-like" symptoms), and the appropriate action patients should take if these signs and symptoms appear.

Anaphylactoid Reactions

As with other NSAIDs, anaphylactoid reactions may occur in patients without prior exposure to diclofenac. Diclofenac should not be given to patients with the aspirin triad. The triad typically occurs in asthmatic patients who experience rhinitis with or without nasal polyps, or who exhibit severe, potentially fatal bronchospasm after taking aspirin or other nonsteroidal anti-inflammatory drugs. Fatal reactions have been reported in such patients (see CONTRAINDICATIONS, and PRECAUTIONS—Preexisting Asthma). Emergency help should be sought in cases where an anaphylactoid reaction occurs.

Advanced Renal Disease

In cases with advanced kidney disease, treatment with diclofenac, as with other NSAIDs, should only be initiated with close monitoring of the patient's kidney functions (see PRECAUTIONS—Renal Effects).

Pregnancy

In late pregnancy, diclofenac should, as with other NSAIDs, be avoided because it will cause premature closure of the ductus arteriosus (see PRECAUTIONS—Pregnancy, *Teratogenic Effects*, *Pregnancy Category B*, and Labor and Delivery).

PRECAUTIONS

General

Cataflam Immediate-Release Tablets, Voltaren Delayed-Release Tablets, and Voltaren-XR Extended-Release Tablets should not be used concomitantly with other diclofenac-containing products since they also circulate in plasma as the diclofenac anion.

Fluid Retention and Edema: Fluid retention and edema have been observed in some patients taking diclofenac. Therefore, as with other NSAIDs, diclofenac should be used with caution in patients with a history of cardiac decompensation, hypertension, or other conditions predisposing to fluid retention.

Hematologic Effects: Anemia is sometimes seen in patients receiving diclofenac or other NSAIDs. This may be due to fluid retention, G.I. blood loss, or an incompletely described effect upon erythropoiesis.

Renal Effects: As a class, NSAIDs have been associated with renal papillary necrosis and other abnormal renal pathology in long-term administration to animals. In oral diclofenac studies in animals, some evidence of renal toxicity was noted. Isolated incidents of papillary necrosis were observed in a few animals at high doses (20-120 mg/kg) in several baboon subacute studies. In patients treated with diclofenac, rare cases of interstitial nephritis and papillary necrosis have been reported (see ADVERSE REACTIONS).

A second form of renal toxicity, generally associated with NSAIDs, is seen in patients with conditions leading to a reduction in renal blood flow or blood volume, where renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients, administration of an NSAID results in a dose-dependent decrease in prostaglandin synthesis and, secondarily, in a reduction of renal blood flow, which may precipitate overt renal failure. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics, and the elderly. Discontinuation of NSAID therapy is typically followed by recovery to the pretreatment state.

Cases of significant renal failure in patients receiving diclofenac have been reported from marketing experience, but were not observed in over 4000 patients in clinical trials during which serum creatinine and BUN values were followed serially. There were only 11 patients (0.3%) whose serum creatinine and concurrent serum BUN values were greater than 2.0 mg/dL and 40 mg/dL, respectively, while on diclofenac (mean rise in the 11 patients: creatinine 2.3 mg/dL and BUN 28.4 mg/dL).

Since diclofenac metabolites are eliminated primarily by the kidneys, patients with significantly impaired renal function should be more closely monitored than subjects with normal renal function.

Porphyria: The use of diclofenac in patients with hepatic porphyria should be avoided. To date, 1 patient has been described in whom diclofenac probably triggered a clinical attack of porphyria. The postulated mechanism, demonstrated in rats, for causing such attacks by diclofenac, as well as some other NSAIDs, is through stimulation of the porphyrin precursor delta-aminolevulinic acid (ALA).

Aseptic Meningitis: As with other NSAIDs, aseptic meningitis with fever and coma has been observed on rare occasions in patients on diclofenac therapy. Although it is probably more likely to occur in patients with systemic lupus erythematosus and related connective tissue diseases, it has been reported in patients who do not have an underlying chronic disease. If signs or symptoms of meningitis develop in a patient on diclofenac, the possibility of its being related to diclofenac should be considered.

Preexisting Asthma: About 10% of patients with asthma may have aspirin-sensitive asthma. The use of aspirin in patients with aspirin-sensitive asthma has been associated with severe bronchospasm which can be fatal. Since cross-reactivity, including bronchospasm, between aspirin and other nonsteroidal anti-inflammatory drugs has been reported in such aspirin-sensitive patients, diclofenac should not be administered to patients with this form of aspirin sensitivity and should be used with caution in all patients with preexisting asthma.

Other Precautions: The pharmacologic activity of diclofenac may reduce fever and inflammation, thus diminishing their utility as diagnostic signs in detecting underlying conditions.

In order to avoid exacerbation of manifestations of adrenal insufficiency, patients who have been on prolonged corticosteroid treatment should have their therapy tapered slowly rather than discontinued abruptly when diclofenac is added to the treatment program.

Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If a patient develops such complaints while receiving diclofenac, the drug should be discontinued and the patient should have an ophthalmologic examination which includes central visual fields and color vision testing.

Information for Patients

Diclofenac, like other drugs of its class, is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, more serious side effects, such as gastrointestinal bleeding, and more rarely, liver toxicity (see WARNINGS, Hepatic Effects), which may result in hospitalization and even fatal outcomes.

NSAIDs are often essential agents in the management of arthritis and have a major role in the management of pain, but they also may be commonly employed for conditions that are less serious.

Physicians may wish to discuss with their patients the potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS) and likely benefits of NSAID treatment, particularly when the drugs are used for less serious conditions where treatment without NSAIDs may represent an acceptable alternative to both the patient and physician.

Because serious G.I. tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding and should inform them of the importance of this follow-up (see WARNINGS, Gastrointestinal Effects, *Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy*). If diclofenac is used chronically, patients should also be instructed to report any signs and symptoms that might be due to hepatotoxicity of diclofenac; these symptoms may become evident

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between visits when periodic liver laboratory tests are performed (see WARNINGS, Hepatic Effects, and PRECAUTIONS–Laboratory Tests).

Laboratory Tests

Hepatic Effects: Transaminases and other hepatic enzymes should be monitored in patients treated with NSAIDs. For patients on diclofenac therapy, it is recommended that a determination be made within 4 weeks of initiating therapy and at intervals thereafter. If clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g. eosinophilia, rash, etc.) and abnormal liver tests are detected, persist or worsen, diclofenac should be discontinued immediately.

Hematologic Effects: Patients on long-term treatment with NSAIDs, including diclofenac, should have their hemoglobin or hematocrit checked periodically for signs or symptoms of anemia. Appropriate measures should be taken in case such signs of anemia occur.

Drug Interactions

Aspirin: Concomitant administration of diclofenac and aspirin is not recommended because diclofenac is displaced from its binding sites during the concomitant administration of aspirin, resulting in lower plasma concentrations, peak plasma levels, and AUC values.

Anticoagulants: While studies have not shown diclofenac to interact with anticoagulants of the warfarin type, caution should be exercised, nonetheless, since interactions have been seen with other NSAIDs. Because prostaglandins play an important role in hemostasis, and NSAIDs affect platelet function as well, concurrent therapy with all NSAIDs, including diclofenac, and warfarin requires close monitoring of patients to be certain that no change in their anticoagulant dosage is required.

Digoxin, Methotrexate, Cyclosporine: Diclofenac, like other NSAIDs, may affect renal prostaglandins and increase the toxicity of certain drugs. Ingestion of diclofenac may increase serum concentrations of digoxin and methotrexate and increase cyclosporine's nephrotoxicity. Patients who begin taking diclofenac or who increase their diclofenac dose or any other NSAID while taking digoxin, methotrexate, or cyclosporine may develop toxicity characteristics for these drugs. They should be observed closely, particularly if renal function is impaired. In the case of digoxin, serum levels should be monitored.

Lithium: Diclofenac decreases lithium renal clearance and increases lithium plasma levels. In patients taking diclofenac and lithium concomitantly, lithium toxicity may develop.

Oral Hypoglycemics: Diclofenac does not alter glucose metabolism in normal subjects nor does it alter the effects of oral hypoglycemic agents. There are rare reports, however, from marketing experiences, of changes in effects of insulin or oral hypoglycemic agents in the presence of diclofenac that necessitated changes in the doses of such agents. Both hypo- and hyperglycemic effects have been reported. A direct causal relationship has not been established, but physicians should consider the possibility that diclofenac may alter a diabetic patient's response to insulin or oral hypoglycemic agents.

Diuretics: Diclofenac and other NSAIDs can inhibit the activity of diuretics. Concomitant treatment with potassium-sparing diuretics may be associated with increased serum potassium levels.

Other Drugs: In small groups of patients (7-10/interaction study), the concomitant administration of azathioprine, gold, chloroquine, o-penicillamine, prednisolone, doxycycline, or digitoxin did not significantly affect the peak levels and AUC values of diclofenac. Phenobarbital toxicity has been reported to have occurred in a patient on chronic phenobarbital treatment following the initiation of diclofenac therapy.

Protein Binding

In vitro, diclofenac interferes minimally or not at all with the protein binding of salicylic acid (20% decrease in binding), tolbutamide, prednisolone (10% decrease in binding), or warfarin. Benzylpenicillin, ampicillin, oxacillin, chlortetracycline, doxycycline, cephalothin, erythromycin, and sulfamethoxazole have no influence *in vitro* on the protein binding of diclofenac in human serum.

Drug/Laboratory Test Interactions

Effect on Blood Coagulation: Diclofenac increases platelet aggregation time but does not affect bleeding time, plasma thrombin clotting time, plasma fibrinogen, or factors V and VII to XII. Statistically significant changes in prothrombin and partial thromboplastin times have been reported in normal volunteers. The mean changes were observed to be less than 1 second in both instances, however, and are unlikely to be clinically important. Diclofenac is a prostaglandin synthetase inhibitor, however, and all drugs that inhibit prostaglandin synthesis interfere with platelet function to some degree; therefore, patients who may be adversely affected by such an action should be carefully observed.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in rats given diclofenac sodium up to 2 mg/kg/day (or 12 mg/m²/day, approximately the human dose) have revealed no significant increases in tumor incidence. There was a slight increase in benign mammary fibroadenomas in mid-dose-treated (0.5 mg/kg/day or 3 mg/m²/day) female rats (high-dose females had excessive mortality), but the increase was not significant for this common rat tumor. A 2-year carcinogenicity study conducted in mice employing diclofenac sodium at doses up to 0.3 mg/kg/day (0.9 mg/m²/day) in males and 1 mg/kg/day (3 mg/m²/day) in females did not reveal any oncogenic potential. Diclofenac sodium did not show mutagenic activity in *in vitro* point mutation assays in mammalian (mouse lymphoma) and microbial (yeast, Ames) test systems and was nonmutagenic in several mammalian *in vitro* and *in vivo* tests, including dominant lethal and male germinal epithelial chromosomal studies in mice, and nucleus anomaly and chromosomal aberration studies in Chinese hamsters. Diclofenac sodium administered to male and female rats at 4 mg/kg/day (24 mg/m²/day) did not affect fertility.

Pregnancy, Teratogenic Effects, Pregnancy Category B

Reproduction studies have been performed in mice given diclofenac sodium (up to 20 mg/kg/day or 60 mg/m²/day) and in rats and rabbits given diclofenac sodium (up to 10 mg/kg/day or 60 mg/m²/day for rats, and 80 mg/m²/day for rabbits), and have revealed no evidence of teratogenicity despite the induction of maternal toxicity and fetal toxicity. In rats, maternally toxic doses were associated with dystocia, prolonged gestation, reduced fetal weights and growth, and reduced fetal survival. Diclofenac has been shown to cross the placental barrier in mice and rats. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should not be used during pregnancy unless the benefits to the mother justify the potential risk to the fetus. Because of the risk to the fetus resulting in premature closure of the ductus arteriosus, diclofenac should be avoided in late pregnancy.

Labor and Delivery

The effects of diclofenac on labor and delivery in pregnant women are unknown. Because of the known effects of prostaglandin-inhibiting drugs on the fetal cardiovascular system (closure of ductus arteriosus), use of diclofenac during late pregnancy should be avoided and, as with other nonsteroidal anti-inflammatory drugs, it is possible that diclofenac may inhibit uterine contractions and delay parturition.

Nursing Mothers

Because of the potential for serious adverse reactions in nursing infants from diclofenac, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Safety and effectiveness of diclofenac in pediatric patients have not been established.

Geriatric Use

Of the more than 6000 patients treated with diclofenac in U.S. trials, 31% were older than 65 years of age. No overall difference was observed between efficacy, adverse event, or pharmacokinetic profiles of older and younger patients. As with any NSAID, the elderly are likely to tolerate adverse reactions less well than younger patients.

ADVERSE REACTIONS

Adverse reaction information is derived from blinded, controlled, and open-label clinical trials, as well as worldwide marketing experience. In the description below, rates of more common events represent clinical study results; rarer events are derived principally from marketing experience and publications, and accurate rate estimates are generally not possible.

In 718 patients treated for shorter periods, i.e., 2 weeks or less, with Cataflam Immediate-Release Tablets, adverse reactions were reported one-half to one-tenth as frequently as by patients treated for longer periods. In a 6-month, double-blind trial comparing Cataflam Immediate-Release Tablets (N=196) versus Voltaren Delayed-Release Tablets (N=197) versus ibuprofen (N=197), adverse reactions were similar in nature and frequency. In controlled clinical trials, the incidence of adverse reactions for Voltaren Delayed-Release Tablets and Voltaren-XR Extended-Release Tablets at comparable doses were similar.

The incidence of common adverse reactions (greater than 1%) is based upon controlled clinical trials in 1543 patients treated up to 13 weeks with Voltaren Delayed-Release Tablets. By far the most common adverse effects were gastrointestinal symptoms, most of them minor, occurring in about 20%, and leading to discontinuation in about 3%, of patients. Peptic ulcer or G.I. bleeding occurred in clinical trials in 0.6% (95% confidence interval: 0.2% to 1%) of approximately 1800 patients during their first 3 months of diclofenac treatment and in 1.6% (95% confidence interval: 0.8% to 2.4%) of approximately 800 patients followed for 1 year.

Gastrointestinal symptoms were followed in frequency by central nervous system side effects such as headache (7%) and dizziness (3%).

Meaningful (exceeding 3 times the Upper Limit of Normal) elevations of ALT (SGPT) or AST (SGOT) occurred at an overall rate of approximately 2% during the first 2 months of Voltaren treatment. Unlike aspirin-related elevations, which occur more frequently in patients with rheumatoid arthritis, these elevations were more frequently observed in patients with osteoarthritis (2.6%) than in patients with rheumatoid arthritis (0.7%). Marked elevations (exceeding 8 times ULN) were seen in 1% of patients treated for 2-6 months (see WARNINGS, Hepatic Effects).

The following adverse reactions were reported in patients treated with diclofenac:

Incidence Greater Than 1% - Causal Relationship Probable:

(All derived from clinical trials.)

*Incidence, 3% to 9% (incidence of unmarked reactions is 1%-3%).

Body as a Whole: Abdominal pain or cramps,* headache,* fluid retention, abdominal distention.

Digestive: Diarrhea,* indigestion,* nausea,* constipation,* flatulence, liver test abnormalities,* PUB, i.e., peptic ulcer, with or without bleeding and/or perforation, or bleeding without ulcer (see above and also WARNINGS).

Nervous System: Dizziness.

Skin and Appendages: Rash, pruritus.

Special Senses: Tinnitus.

Incidence Less Than 1% - Causal Relationship Probable:

(Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are *italicized*.)

Body as a Whole: Malaise, swelling of lips and tongue, photosensitivity, *anaphylaxis*, *anaphylactoid* reactions.

Cardiovascular: Hypertension, congestive heart failure.

Digestive: Vomiting, jaundice, melena, *esophageal lesions*, aphthous stomatitis, dry mouth and mucous membranes, bloody diarrhea, hepatitis, *hepatic necrosis*, *cirrhosis*, *hepatorenal syndrome*, appetite change, pancreatitis with or without concomitant hepatitis, *colitis*.

Hemic and Lymphatic: Hemoglobin decrease, leukopenia, thrombocytopenia, *eosinophilia*, *hemolytic anemia*, *aplastic anemia*, *agranulocytosis*, *purpura*, *allergic purpura*.

Metabolic and Nutritional Disorders: Azotemia.

Nervous System: Insomnia, drowsiness, depression, diplopia, anxiety, irritability, *aseptic meningitis*, *convulsions*.

Respiratory: Epistaxis, asthma, laryngeal edema.

Skin and Appendages: Alopecia, urticaria, eczema, dermatitis, *bullous eruption*, *erythema multiforme major*, angioedema, *Stevens-Johnson syndrome*.

Special Senses: Blurred vision, taste disorder, reversible and irreversible hearing loss, scotoma.

Urogenital: *Nephrotic syndrome*, proteinuria, *oliguria*, *interstitial nephritis*, *papillary necrosis*, *acute renal failure*.

Incidence Less Than 1% - Causal Relationship Unknown:

(The following reactions have been reported in patients taking diclofenac under circumstances that do not permit a clear attribution of the reaction to diclofenac. These reactions are being included as alerting information to physicians. Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are *italicized*.)

Body as a Whole: Chest pain.

Cardiovascular: Palpitations, *flushing*, tachycardia, premature ventricular contractions, myocardial infarction, *hypotension*.

Digestive: *Intestinal perforation*.

Hemic and Lymphatic: Bruising.

Metabolic and Nutritional Disorders: Hypoglycemia, *weight loss*.

Nervous System: Paresthesia, memory disturbance, nightmares, tremor, tic, *abnormal coordination*, *disorientation*, *psychotic reaction*.

Respiratory: Dyspnea, hyperventilation, edema of pharynx.

Skin and Appendages: Excess perspiration, *exfoliative dermatitis*.

Special Senses: Vitreous floaters, night blindness, amblyopia.

Urogenital: Urinary frequency, nocturia, hematuria, impotence, vaginal bleeding.

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The PBT Challenge

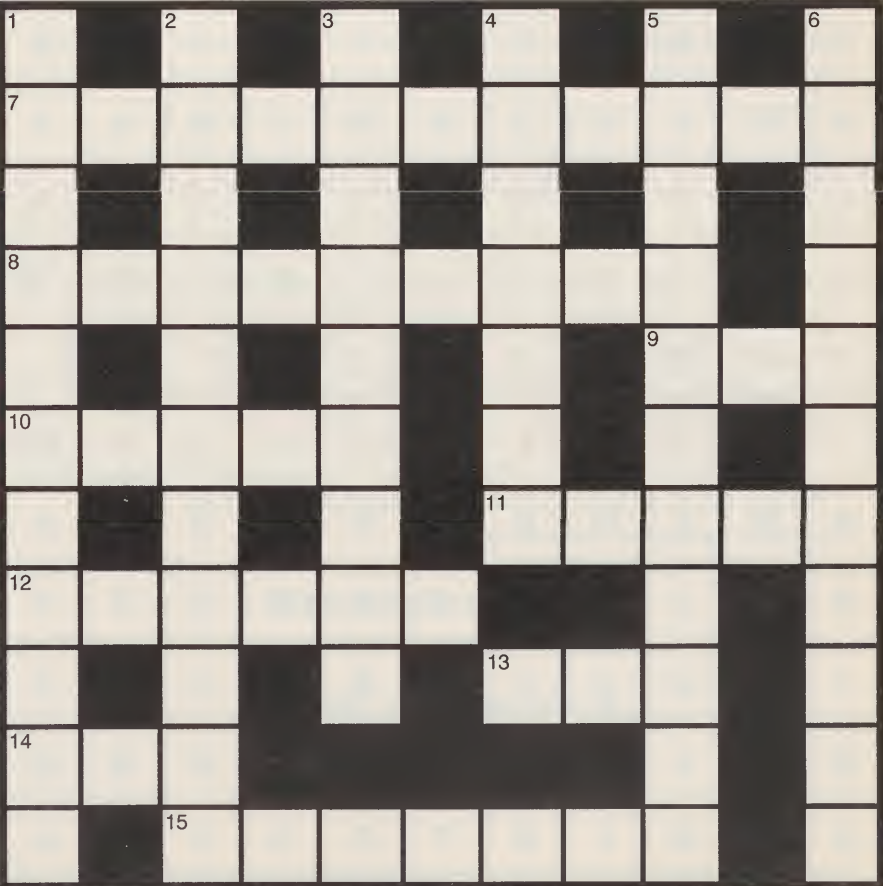
Solution In This Issue
This crossword puzzle, like our PBT benefit plans, is designed especially for physicians!

Across

- 7. Planar xanthoma involving the eyelids
- 8. Essential in the nutrition of a microorganism
- 9. Ribonucleic acid
- 10. A contagious scabies-like dermatitis caused by mange mites
- 11. The crest of the tibia
- 12. Ten millimeters (as a unit)
- 13. Not well
- 14. Poliovirus vaccine
- 15. Brand of Aspirin

Down

- 1. Unconsciousness; coma
- 2. Without reason
- 3. A genus of minute tickborne protozoa (Order Piroplasmida, Subclass Piroplasmia)
- 4. Inflammation of the ileum
- 5. Vegetable hematin
- 6. Saddle nose



Fully furnished office, X-rays, etc. Close to hospitals. Part-time use or rent by the day. Contact Mrs. Reinwein, 1920 Seventh St., Moline, IL 61265. Call (309) 762-3397.

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Nineteenth Annual British Virgin Islands Medical Conference, Feb. 3-7, 1997. Prospect Reef Resort, Road Town, Tortola. For more information, call or write Julie S. Lucas, Butterworth Hospital, Grand Rapids, MI 49503. Telephone (616) 391-2666.

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Alivio Medical Center

MEDICAL DIRECTOR – Alivio Medical Center is a not-for-profit community health center that serves a predominantly Mexican community and is located in the heart of Chicago, four miles from downtown. This position will provide clinical, administrative and teaching leadership; requires managed care experience or compatible practice style and commitment to being a Medical Director; is an integral part of a collaborative management team. Alivio's mission is to serve the uninsured and the working poor, as well as the insured, offering comprehensive primary care to its patients.

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Executive Director

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Doctors lead

(Continued from page 1)

HMOs, DHS officials said the MSO has been able to change the managed care equation for its physicians, guaranteeing a larger flow of patients for doctors who had started to see their practices shrink.

All this was enough to convince Howard Goldman, MD, a solo internist in Overlea, Md., to join the MSO last year. He said he signed up because he believes DHS is a “good marriage of financial incentives and physician control. It’s a physician equity model that has a good chance for potential value through the stock offered.”

According to DHS officials, here's how the system works for physician owners: Physicians sell their practice to DHS and receive cash for the hard assets of the practice, typically \$40,000 to \$50,000. They also receive DHS shares based on the size of their practice. The doctors sign service contracts, typically for five years.

Physicians continue to work in their same locations and make most of the day-to-day management decisions, such as hiring and firing staff, even though the staff technically are DHS employees. DHS takes over the physicians' managed care contracts, and unless the doctors have somehow negotiated better terms, which is rare, DHS subsumes the contracts into its own transactions.

DHS pays doctors their capitation and fee-for-service collections after subtracting the overhead expenses of the office. Physicians still must ask health plans to authorize referrals and hospital admissions under traditional insurance plans, but DHS' \$3 million information system helps streamline the referral process, according to Gold.

For fully capitated patients, DHS approves all referrals, admissions and procedures. DHS establishes its own protocols for its global-risk contracts. "HMOs are willing to give up that control as long as you prove you can handle the risk," Dr. Rifkin said.

Another plus: no more termination-without-cause clauses for physicians. Under the deals negotiated so far, termination from HMO rolls may occur only in the first year doctors are in the plan and only for cause.

DHS lost \$3.2 million in 1995 and expects to lose money this year, but as risk is spread further, profitability should soon follow, according to DHS background information.

Because it has expanded so rapidly, DHS has had to raise financing from private sources. But Gold said the system “is unique in that we have raised all this money without surrendering physician control. Our board has 18 members, only four of whom aren’t physicians. Physicians retain 58 percent ownership of the system.”

DHS was born from what is now one of its member medical groups, Baltimore Medical Group, Dr. Rifkin explained. That group had its roots in 1992 as a physician organization of 17 primary care doctors on the staff of Baltimore's Union Memorial Hospital. The Baltimore Medical Group started with the encouragement of the hospital's administration, which wanted the doctors to become part of a PHO. At that, the doctors balked. "The hospital didn't want a real PHO; they wanted to control us," Dr. Rifkin said.

So the physicians formed an independent practice association outside the hospital structure. Soon, DHS evolved, helping the group become a fully integrated operation sharing back-office operations, unified managed care contracting and professional management, Dr. Rifkin said.

Since then, through a wide array of private investors, DHS has raised \$73 million for such acquisitions as a 470-physician IPA called Montgomery County Network in Baltimore, Gold said. About 50 physicians in this group wound up becoming DHS physician owners, while the others are part of the affiliated IPA.

"It's critical to have agreement among the physician owners as to how this thing is going to be structured and managed," Gold said. "There is no substitute for a strong, professional management structure."

The staff's track record in managed care gave it credibility with potential partners. David Nagel, MD, an internist in Lutherville, Md., who joined DHS in 1994, had a two-person practice based on fee for service. "As a result, my practice was beginning to decline. I just had no experience in negotiating managed care contracts," he said. "So it made sense to join DHS. I have gotten access to Medicare HMO patients I otherwise would not have been able to see." ■

Illinois Medical PS0

(Continued from page 1)

must also be Illinois residents. The minimum investment is five shares of voting-participating preferred stock. Investors who make the minimum purchase may also buy up to 10 additional shares of nonvoting-participating preferred stock. Through mid-October, programs to discuss the PSO and its capitalization are being held in conjunction with the following county medical society meetings: Oct. 1, Vermillion CMS; Oct. 2, Chicago Medical Society North Suburban Branch, Will-Grundy CMS; and Oct. 15, Peoria Medical Society. The stock offering is scheduled to expire Oct. 19.

Growing interest in MSOs led several

DHS services

Doctors Health System provides physicians with practice services "right up to the doctor's front door," said Mark Eig, MD, an internist in Catonsville, Md., who sold his practice and signed a service contract with DHS on Sept. 13. Dr. Eig's contract is "literally a foot thick" and covers every imaginable aspect of his practice, he said.

What isn't in the contract, however, is language telling physicians what to do inside their offices, Dr. Eig said. "In fact, the idea [behind] DHS is returning control of the practice to physicians in a way they may not have right now." Decisions left up to physicians include the types of patients to see, staff hiring and termination, hours worked and hospital affiliations, he noted.

Most physicians don't have the computer systems or staffing capability to manage the care of their patients throughout the health care system – from first contact to clinic visits, referrals to specialists, lab results and clinical outcomes, said Scott Rifkin, MD, DHS chairman.

“Without this kind of information, you can’t keep control of costs and you can’t improve the quality of

care," Dr. Rifkin said.

In addition to taking over physician managed care and fee-for-service contracts, DHS provides the full range of physician management support services, including care management, information systems, billing and collections, management of the networks of specialists for referrals and stop-loss insurance.

Each physician service contract is specific to that doctor's practice, Dr. Rifkin said. The physician, working with DHS, decides how care will be structured. Describing care management, Dr. Rifkin said that seven case managers, who are registered nurses, keep track of each patient interaction, making sure costs are controlled and quality is high and within protocols. "We keep track in real time of which specialist is used, whether the treatment falls into protocols and what the status of the patient is."

Said Dr. Eig: "Doctors can't do it all alone anymore, and if they don't take back some control, managed care companies are going to take that control themselves. [Physicians] don't have the time or the resources to put together a care management system." ■

– Todd Sloane

other state medical societies to commission a case-study analysis of MSOs, which was published earlier this year by the Michigan State Medical Society. The study found that MSOs generally position themselves between payers and providers, adding information systems, administrative expertise and other elements needed to transfer risk to groups of doctors. The MSOs provide an administrative component that was missing in other physician networks such as independent practice associations, the study said. Services provided generally include accounting and finance; billing and collections; group purchasing; information systems; marketing; physician education; recruitment, training and supervision of office staff; risk management protocols; and staff training and development.

MSOs need to begin with a strong capital base because operating deficits are common in the first few years of MSO operation. Undercapitalization can be a problem if physicians are unwilling to make more than a modest investment in physician-owned MSOs. As one physician-owner told the study authors: "Physicians have tended to be fixated on salary and cash, rather than equity. They need to better understand the long-term value of equity."

Those MSOs studied tended to develop long-term relationships with payers and hospitals rather than merely try to optimize their short-term financial arrangements. The most successful MSOs ensure physician leadership on their boards and committees. ■

-Todd Sloane

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Control of Illinois

(Continued from page 1)

cians need to continue working to counter the negative messages that are still being spread about tort reform legislation. More time is needed for the law's full impact to be felt, she added. Klingler's opponent, Marylou Lowder Kent (D-Springfield), is the former legislative lobbyist for the Illinois State Bar Association. "There are groups out there — especially the trial lawyers — that are working hard to reverse [tort reform]," Klingler said. "We need to maintain what we have."



Syverson

In addition to the Klingler-Lowder Kent race, the following House races are expected by legislative analysts to be hotly contested: incumbent Rep. Michael McAuliffe (R-Chicago) vs. Thomas Needham (D-Chicago); incumbent Rep. Jack O'Connor (R-Palos Heights) vs. M. Maggie Crotty (D-Oak Forest); incumbent Rep. Maureen Murphy (R-Oak Lawn) vs. Jim Brosnahan (D-Evergreen Park); incumbent Rep. John Doody (R-Homewood)

vs. Kevin McCarthy (D-Orland Park); Renee Kosel (R-New Lenox) vs. Lois Mayer (D-Mokena); incumbent Rep. Eileen Lyons (R-LaGrange) vs. Mark Pera (D-Western Springs); incumbent Rep. Ron Wait (R-Belvidere) vs. Bill Verda (D-Rockton); incumbent Rep. David Winters (R-Rockford) vs. Vic Verni (D-Rockford); incumbent Rep. Jerry Mitchell (R-Rock Falls) vs. Pennie vonBergen Wessels (D-Sterling); Marvin Lyzenga (R-Lansing) vs. Michael Giglio (D-Lansing); incumbent Rep. Flora Ciarlo (R-Steger) vs. George Scully Jr. (D-Flossmoor); incumbent Rep. Richard Myers (R-Macomb) vs. Tab Turke (D-

Jacksonville); incumbent Rep. Richard Winkel (R-Champaign) vs. Naomi Jakobsson (D-Urbana); incumbent Rep. John Jones (R-Mt. Vernon) vs. Joe Bob Pierce (D-Mt. Vernon); and incumbent Mike Bost (R-Carbondale) vs. John Rendelman (D-Carbondale).

Senate races include incumbent Sen. Walter Dudycz (R-Chicago) vs. Robert Martwick (D-Norridge); Christine Radogno (R-LaGrange) vs. Nancy Kenney (D-LaGrange); incumbent Sen. Aldo DeAngelis (R-Chicago Heights) vs. Deb Halverson (D-Crete); incumbent Sen. Larry Bomke (R-Springfield) vs. Tom Londrigan Jr. (D-Springfield); and David Luechtefeld (R-Okawville) vs. Barbara Brown (D-Chester).

Incumbents who are seeking re-election and voted for H.B. 20, the comprehensive tort reform legislation that passed in 1995, include O'Connor, Murphy, Lyons, Wait, Winters, Mitchell, Ciarlo, Myers, Klingler, Winkel, Jones, Bost, Dudycz, Syverson and DeAngelis.

Syverson, who is a member of the Senate Public Health Committee, said physicians have helped inform him about how health-related measures, including tort reform, would affect physicians and their patients. But he said he would like to see even more involvement from physicians across the state. "I really believe it is imperative that doctors at all levels become more actively involved in the political process. Even taking the time to pick up the phone and call their legislators or to write a quick note just to say, 'This issue is important to me, and I'd like to have your support on it' shows that there is active support for an issue."

IMPAC recently sent questionnaires to candidates to determine their positions on managed care-related issues, and doctors should weigh that information when they decide which candidates to support. Physicians can get information about candidates who completed and returned the forms by calling IMPAC at (312) 782-1963. "There are a lot of [managed care] issues that affect doctors and their ability to direct care and to discuss options with patients," Klingler said.

Two of those issues were addressed during the spring 1996 legislative session when legislators passed laws to prevent "drive-through" deliveries for pregnant women and to allow patients to select Ob/Gyns as their "principal health care providers."

Another issue that legislatures around the country have been examining is the inclusion of gag rules in physicians' contracts. "I think gag rules put physicians in a very awkward situation in which they're not allowed to explain or offer their patients what they believe is the best health care alternative," Syverson said.

Klingler added that physicians shouldn't have to fear recriminations or dismissal from managed care plans for discussing treatment options or for advocating for the best care for their patients. "Too often it seems physicians have to get approval for coverage by calling a toll-free number," she said. "It's not professional to have people who did not ever see the patient have the final say."

Patients also need to know exactly what their managed care plans cover before they decide to join, Klingler said. Too often, she said, people sign up and then realize a treatment isn't covered. Clearer directions and guidelines would let patients know beforehand what treatments would be covered.



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IDPR DISCIPLINES

This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

April 1995

Michael Elliott, Robinson – physician and surgeon license reprimanded after allowing a nurse, under his supervision, to sign his name and the nurse's name to prescriptions for controlled substances prior to becoming aware that the Controlled Substances Act and Rules required he personally sign said prescriptions.

Stephen P. Kikel, Glenview – physician and surgeon license renewed and placed on probation for one year after being disciplined in the state of Ohio.

David L. Samuel, Springfield – physician and surgeon license suspended for 90 days, followed by indefinite probation, after being disciplined in the state of Wisconsin.

May 1995

Charles Bell, Chicago – physician and surgeon license reprimanded and fined \$1,400 after practicing on a nonrenewed license.

Franklin C. Miller, Chicago – physician and surgeon license reprimanded and fined \$1,000 after practicing on a nonrenewed license.

June 1995

Joseph J. Cichon, Streator – physician and surgeon license and controlled substance license indefinitely revoked after allegedly videotaping himself rubbing a liquid on the buttocks and vagina of a nude female patient, under the age of 13, and inserting his fingers in her anus and vagina; and fondling and videotaping other nude minor female patients.

July 1995

George Barnett, Chicago – physician and surgeon license restored to indefinite probation.

Frank O. Becker, Monee – physician and surgeon license indefinitely suspended due to conviction for federal tax evasion.

Kwabena Boateng, Joliet – physician and surgeon license indefinitely suspended after practicing on a nonrenewed license.

Sidney Camras, Chicago – physician and surgeon license and controlled substance license placed on probation for two years after allegedly prescribing a controlled substance to a department investigator in a nontherapeutic manner.

Dario T. Lebajo, Chicago – physician and surgeon license reprimanded due to failure to report action taken against him by Adolph Meyer Mental Health and Developmental Center.

Amelia Susan Lipezker, Chicago – physician and surgeon license indefinitely suspended for failure to diagnose or treat a patient for symptoms of cardiac distress, and when patient was correctly diagnosed by other physicians, patient could not be immediately treated due to deteriorating physical condition and subsequently died after surgery.

Brian Molstad, Decatur – physician and surgeon license indefinitely suspended after being disciplined in the state of Minnesota.

Atiya Murtuza, Center Line, Mich. – physician and surgeon license indefinitely

suspended after being disciplined in the state of Michigan.

Miguel Ochoa, Danville – physician and surgeon license and controlled substance license placed on probation for two years after allegedly prescribing controlled substances to several patients that were excessive and contrary to the overall medical health of his patients.

Arthur Sakamoto, Lakewood, Colo. – physician and surgeon license indefinitely suspended after being disciplined in the

state of California.

Arnold Samuels, Evanston – physician and surgeon license reprimanded and fined \$1,700 after practicing on a nonrenewed license.

Al R. Shreim, aka Alex R. Shreim, Chesterfield, Mo. – physician and surgeon license revoked after being convicted of the felonies of conspiracy to commit mail fraud, mail fraud, and aiding and abetting due to involvement in a Workman's Compensation fraud scheme, and is currently a fugitive

with an arrest warrant being issued.

Edwin Siroy, Shelbyville – physician and surgeon license placed on probation for four years, and controlled substance license suspended for one year followed by four years' probation after allegedly prescribing anorectic medications, Valium, and Hycodan to a department undercover investigator in a nontherapeutic manner, dispensing more than 100,000 anorectic tablets yearly from his office, and failing to make and maintain proper controlled-substance dispensing logs as required by law.

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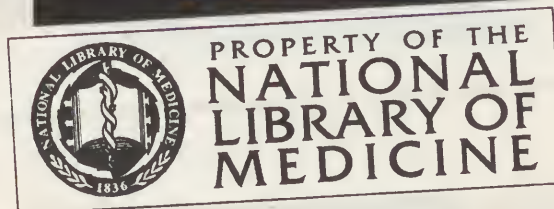
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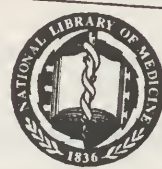
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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • OCTOBER 11 1996

State provides
death certificate
tips

PAGE 2



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Medical-society-developed corporation supports Pennsylvania physicians

MANAGED CARE: Company helps physicians gain market clout. BY JANE ZENTMYER

[HARRISBURG, PA.] Shock waves traveled through the medical community in Berks County, Pa., when one of several local hospitals set up an exclusive contract with an HMO with which it had previously refused to do business and gave physicians who were already under contract with the

HMO only two weeks to join the hospital's medical staff or be terminated from the HMO, according to William West, MD, an Ob/Gyn in Reading, Pa. That event accelerated the local movement to form a physician organization that would support physicians in an increasingly managed care envi-

ronment, he said.

Physicians turned to the PennMed Member Services Co. (PMSCO), a corporation formed by the Pennsylvania Medical Society in 1994 to provide physicians the services, support and expertise to be successful in a maturing managed care market, Dr. West said. "They're physician advocates," said Dr. West, who now serves as president of the Berks County Provider Organization. "In negotiations with managed care companies, they are strong proponents of the fact that physicians are the ones who have to be in control of the future."

PMSCO is helping physicians develop local and regional POs around the state so that doctors can prepare to take more risk - for instance, through capitation - and reap the financial awards of that increased risk, according to Mike Lance, PMSCO's chief executive officer. "Our ultimate goal is to allow patients access

(Continued on page 10)

Illinois Medical PSO will provide expertise

Like the PennMed Member Services Co., the Illinois Medical Physician Services Organization Inc. has been organized to empower physicians by providing the tools, services and expertise they need to develop and operate entities capable of contracting with employers and insurers.

When capitalized, the independent, for-profit company will tailor its services to meet the individual needs of physicians. Those services will include assistance in negotiation and contracting, practice development, administrative and financial planning, managed care operations and capital formation. But the PSO needs physicians' financial support before it can be implemented.

Illinois physicians have a little more than a week to invest in the Illinois Medical PSO before the stock offering is sched-

(Continued on page 10)

New federal antitrust guidelines open opportunities for physician networks

CHANGES: Doctors can now compete more equally with insurers and HMOs. BY DEBORAH PREISER

[WASHINGTON] Revised antitrust guidelines issued in late August by the Federal Trade Commission and the U.S. Department of Justice will make it easier for Illinois physicians to form physician-owned health care networks and other joint ventures to compete with insurance companies and HMOs. Deemed to be more physician-friendly, the guidelines allow a broad range of fee-for-service networks to be legal under the antitrust laws.

"By revising their guidelines, the federal government seems to be saying that it's OK for physicians to band together to provide services and become mas-

ters of their fate," said ISMS General Counsel Saul Morse. By taking this action, federal officials appear to have recognized that the previous antitrust guidelines, issued in 1994, "impeded the attempts of individual physicians and small practices to create networks," he added.

"Concerns about antitrust accusations certainly created hurdles for physicians who wanted to form networks in the past and made it possible for nonphysician-managed networks to seize opportunities in the rapidly changing health field," Morse explained.

Under former federal anti-

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doctor prescribes
fitness for peers



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John McNitt

ILLINOIS ATTORNEY GENERAL Jim Ryan (right) outlines his plan to combat domestic violence at a Sept. 12 news conference in Chicago. With Ryan are ISMS President Sandra Olson, MD (left), and Cook County State's Attorney Jack O'Malley.

State will sue tobacco companies, Ryan says

SMOKING: Lawsuit will seek to recover Medicaid funds spent on smoking-related health care between 1980 and 1993. BY JANE ZENTMYER

[CHICAGO] The state of Illinois will sue tobacco companies in an effort to recoup some of the money taxpayers spent on smoking-related health care costs, Attorney General Jim Ryan announced Sept. 17. Illinois will be one of at least 15 states that have filed such lawsuits in either state or federal court since 1994.

"I believe the state can prove in court that the tobacco companies are engaged in misrepresentation, omission of material fact, deception and conspiracy that ultimately shortened lives and shortchanged taxpayers," Ryan said. "The task before us is a daunting one. Yet we will proceed forcefully to recover what has been taken from Illinois taxpayers."

Ryan assembled a team of his top lawyers in March to begin considering filing a lawsuit. The team did extensive

legal research to determine the feasibility of such a suit in Illinois, Ryan said.

"Back in April, the ISMS House of Delegates asked the attorney general to consider this lawsuit," said ISMS President Sandra Olson, MD. "We enthusiastically support and encourage him in this effort and will cooperate in any way we can."

The state spent about \$2.75 billion in smoking-related health care costs between 1980 and 1993, Ryan said. The figures come from a study released by the American Lung Association of Illinois in late July - a study also used by Mississippi, the first state to file a lawsuit against tobacco companies. The study was conducted by the Robert Wood Johnson Tobacco Policy Research and Evaluation Program and U.S. Centers for Disease Control and Prevention.

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State provides death certificate tips

DATA: Precise information is needed to fulfill legal requirements and provide research statistics. BY JANE ZENTMYER

[SPRINGFIELD] During October and November, the Illinois Department of Public Health will send information about completing death certificates to all Illinois physicians. The mailing is a one-page, double-sided informational laminate that details the steps physicians should take and the information they should include to complete their portion of death certificates, according to IDPH.

"Physicians have informed us that during their formal education, no one has really instructed them on the how-tos of completing the cause of death,"

said Steven Perry, the deputy state registrar. "This laminate highlights the points we feel are very important."

Death certificate information generates national and state mortality statistics, Perry said. The information also helps public health officials assess the health of the population, identify public health problems and determine the success of medical treatments and interventions. In addition, the statistics are considered in allocating federal and state health services and developing programs.

The certificates include a two-part

cause-of-death section, the first of which asks physicians to list immediate causes of death. Physicians should be specific, Perry said. "We're looking for the physicians's best diagnosis of exactly what caused the demise of the individual." In the second section, doctors should describe the "diseases and injuries that initiated the chain of events leading directly to the individual's death."

As an example, the Physicians' Handbook on Medical Certification of Death, published by the U.S. Department of Health and Human Services, provides the following case history and the related entry on the death certificate: A 34-year-old male was admitted to the hospital with shortness of breath. Tests confirmed the patient had HIV. A transbronchial lung biopsy performed by bronchoscopy was positive for *Pneumocystis carinii* pneumonia, indicating a diagnosis of acquired immunodeficiency syndrome. The patient eventually died of pneumonia. The death certificate should list the immediate cause of death as pneumocystis *carinii* pneumonia and the underlying causes as acquired immunodeficiency syndrome and HIV infection.

Occasionally a record goes through the system with only general statements or terminology that isn't useful to researchers and statisticians, such as listing cardiac or respiratory arrest or heart failure as a cause of death, Perry said. Local registrars, who collect the certificates, make every effort to ensure that certificates are filled out thoroughly and appropriately, and they may contact the physician or funeral

director to get more data.

State law requires funeral directors to file the death certificate with a local registrar seven days from the date of death, Perry said. Physicians have 48 hours from the time of death to complete and sign the medical portion of the death certificate and then make it available to the funeral director, who usually files the certificate with the local registrar, Perry said. The exact method of returning the certificate to the funeral director often varies regionally, he added. In a physician's absence, he or she may designate another party – an associate physician, the chief medical officer of the institution in which the death occurred or the physician who performed the autopsy – to complete the death certificate, according to IDPH.

The 48-hour return requirement allows the funeral director to meet the seven-day requirement and keeps the certificate moving through the process, Perry said. That, in turn, helps families get on with closing estates, fulfilling wills and other legal matters, he said.

When a death is subject to investigation by the coroner or the medical examiner or occurs without medical attendance, the coroner or medical examiner is responsible for completing the death certificate and must sign it within 48 hours after the death unless there are special exceptions. Physicians should contact the medical examiner or coroner if they are unsure about which cases they should refer, Perry said.

For information about death certificates, call the state registrar's office at (800) 237-1945. ■

Time is running out to renew your medical license

Physicians who fail to renew their medical licenses in October will face serious consequences. The grace period expires at the end of the month, and any physician who does not have a new three-year license then will be practicing medicine without a license. Possible penalties include fines and disciplinary action by the state Medical Disciplinary Board. In addition, most medical malpractice insurers, including ISMIE, lapse coverage for the time physicians practice without a valid license.

Physicians who have not renewed their license must immediately send their completed renewal forms, along with full payment, to the Illinois Department of Professional Regulation. For physicians renewing now, a \$100 late fee applies. The cost of a standard three-year, in-state renewal, including the late fee, is \$400; out-of-state renewals are now \$700 with the late fee. Physicians may contact the department at (217) 782-0458 to request forms but should allow ample time for mailing and processing.

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Bloomington doctor prescribes physical fitness for peers

Ophthalmologist finishes Boston Marathon and is still running.

BY DEBORAH PREISER

[BLOOMINGTON] Three hours and 41 minutes after the start of the 100th Boston Marathon last spring, Catharine Crockett, MD, finished the 26.2-mile trek and crossed the finish line. After months of running alone in the early morning hours on the empty streets of Bloomington, the ophthalmologist found that the cheering crowds along the route gave her a boost. "They definitely made it easier," said Dr. Crockett, who finished in the top half of all the marathon runners and the top quarter of all the women runners. "I had no idea the entire course was so hilly. After training on the flatlands of central Illinois, I wasn't sure I could do this [after] I took a bus tour of the route the day before the race."

Until last year, Dr. Crockett thought she had run her last marathon more than a decade ago while working as a researcher at the Indiana University Medical Center. She was relatively new to the sport of running when she was accepted at the Indiana University Medical School. Her goal then: to train and run at least one marathon before starting the grind of medical school.

In the Terre Haute Marathon, Dr. Crockett finished second among all the women runners and missed qualifying for the Boston Marathon by just four minutes. "I was very happy. I had been running 70 to 80 miles a week and figured I'd never again have that kind of time to devote to training."

During school and her subsequent internship at Wills Eye Hospital in Philadelphia, Dr. Crockett kept running. After she joined a practice in Bloomington, fellow runner and general surgeon Richard Trefzger, MD, recommended Jeff Galloway's "Book on Running." In it, the author describes his graduated approach to training for a marathon run – a plan that doesn't prescribe the megadose of training hours most runners cram into their schedules. "I bought into Galloway's philosophy," Dr. Crockett said.

She said she followed a "fairly minimal" running routine, starting out about 5:30 or 6 a.m. a couple of days a week and clocking three or four miles before her first appointment or meeting. On weekends, she followed the Galloway method of slowly building up to a marathon run. Needing a qualifying marathon time to enter the Boston race, she entered the 1995 Chicago Marathon and finished in 3:39:41 despite an upset

stomach that gave her "a look at the inside of a lot of port-a-potties" along the route. In spite of her illness, she still qualified for the Boston Marathon.

With that accomplishment complete, Dr. Crockett is not about to hang up her running shoes: "I like the solitude. Run-

ning is like meditation. Even when it seems painful to pull myself out of bed, I start running in the early morning light and listen to the birds sing and feel great. It's definitely a stress reliever for me – except when I was training for Boston. Finding time to train became a big stress inducer when my schedule got very busy."

While Dr. Crockett said she recognizes that long-distance running is not for everyone, she hopes physicians of her generation will do more than doctors in the past did to set an example of fitness for their patients: "Even if you don't run, do something physical. Be a role model." ■

Physician HELpline

ISMS' 24-hour Physician HELpline is available to link impaired physicians and their families with helpful resources.

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REPORT for Illinois Physicians

GUIDELINES CHANGE for SERVICES of TEACHING PHYSICIANS

Beginning July 1, 1996, Health Care Financing Administration (HCFA) removed the attending physician requirement for teaching physicians and implemented new guidelines. The new guidelines require the presence of a teaching physician during the key portion of the performance of a service in which a resident is involved for which carrier payment will be sought by the teaching physician.

For evaluation and management services, the physician must be present during the portion of the service that determines the level of service billed. HCFA is providing an exception to the physician presence requirement for certain low and mid-level evaluation and management services (Physicians' Current Procedural Terminology codes 99201 - 99203, and 99211 - 99213) furnished in certain primary care centers when all of the following conditions are met:

- 1) The services must be furnished in a center which may be located in a hospital outpatient department or in a free standing setting in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital.
- 2) The patients seen are an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians.
- 3) The services furnished include:
 - a) acute care for undifferentiated problems or chronic care for ongoing conditions;
 - b) coordination of care furnished by other physicians and providers;
 - c) comprehensive care not limited by organ system, diagnosis or gender.
- 4) The resident furnishing the service without the presence of a teaching physician has completed more than six months of an approved residency program.
- 5) There is a teaching physician directing the care of no more than four (4) residents at any given time from such proximity as to constitute immediate availability who
 - a) has no other responsibilities at the time;
 - b) assumes management responsibility to those beneficiaries seen by the residents;
 - c) ensures that the services provided are appropriate;
 - d) review with each resident during or immediately after each visit, the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies; and,
 - e) documents the extent of his/her participation in the review and direction of the services furnished to each beneficiary.
6. The residents must follow the same group of patients throughout the course of their residency program.
7. The care is included in the full time equivalency count used by the intermediary in making direct GME payments.
8. This exception applies to only low level E/M codes (levels 1, 2 and 3). For higher level services and all invasive procedures, the teaching physician must be present.
9. All other Medicare Program restrictions apply (e.g., screening services).

(Issue: 10/11/96 - DB)

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EDITORIAL

Let's get moving

Research is showing that our national pastime of baseball has been replaced – by inactivity. Even those who don't share Harry Caray's enthusiasm for the game have to admit that baseball isn't usually dangerous. Unfortunately, the same can't be said of Americans' passion for lethargy.

A study released this summer by the Cooper Institute for Aerobic Research and published in JAMA showed that low fitness is as important a risk factor as smoking and more powerful than high blood pressure, high cholesterol, obesity or family history. The combination of poor fitness and smoking nearly doubled the risk of early death for men and women, according to the study, in which physicians followed participants for an average of 8.5 years, looking for common factors among those who survived and those who died. Amazingly, participants who were fit but had various risk factors were less likely to die than those who were not fit but were otherwise healthy.

The good news from the study was that to live longer, people need to maintain only moderate fitness – not the prowess of professional athletes or health club addicts. The mortality rate for moderately fit nonsmoking men was 41 percent lower than the rate for nonsmoking men in poor aerobic shape. The Cooper study's lead author said people could achieve moderate fitness by walking a mile and a half in 35 minutes, for instance.

Another study, published last year in the Archives of Pediatrics and Adolescent Medicine, found an increase in the prevalence of overweight for young people that is similar to that for adults. The Archives study attributed part of the problem to inactivity: Only 25 percent of U.S. high school students took daily physical education last year, down from 42 percent five years ago, according to a surgeon general report in July. Four out of 10 high school students received no physical education at all last year. Compounding the lack of physical activity is our love of such passive entertainments as video games and television. More than 70 percent of students in grades nine through 12 reported watching at least one hour of television each school day, and more than 35 percent reported watching at least three hours each school day, according to the 1990 Youth Risk Behavior Survey. On the positive side, though, Illinois is currently the only state that requires daily physical education for young people in school, according to the New York Times.

Physicians should practice what they prescribe when it comes to moderate exercise. A physician interviewed for the story on page 3 of this issue should inspire us. She's a Bloomington ophthalmologist who ran in the Boston Marathon last spring and was able to fit a "fairly minimal" training routine into a couple of days a week. Her advice to physicians: "Do something physical. Be a role model."

PRESIDENT'S LETTER

It's all in the genes

Sandra F. Olson, MD



How do we protect the rights of people who are doomed to develop a disease like Huntington's?

Have you checked your genes lately? All 100,000 of them? This may soon be possible if the goal of the Human Genome Project is reached and all 3 billion DNA sequences in the human genome are localized by 2005. Six-thousand human genes have already been identified, and new ones responsible for diseases are being discovered almost weekly.

Now comes the important question. What will we do with this knowledge? How will we apply these techniques in a responsible, ethical and humane way when we are able to scrape a few cells and print out a person's genetic code? This is a sobering and practical question we must answer and quickly. Let's consider a recent, well-publicized example.

BRCA1 is a gene associated with breast and ovarian cancer. Women with a family history of breast cancer who are positive for this gene have an 85 percent likelihood of developing breast cancer and a 50 percent risk of ovarian cancer, according to Francis Collins, MD, PhD, director for the National Center for Human Genome Research. Women who do not have the gene have a one-in-eight chance of developing breast cancer. Knowing this, whom do we test? Some say testing should remain a research tool because there is a lack of correlation between predicting the risk and preventing occurrence of the disease. Others advocate free access to the test for any woman who wants it, citing the right of those at risk to consider potential life-planning measures. Counseling people who choose to undergo such testing is another integral part of this entire process and cannot be underestimated.

Some genetic information only predicts risk, but other genes carry an inevitable incidence of a disorder, and that knowledge is even more problematic. Huntington's disease is a good example. If individuals have that gene, they have a 100 percent chance of developing this devastating illness. If known in advance, this information

can be extremely depressing for those who have a picture of what this illness can do, because they may have lived through it with a loved one. But early knowledge, before childbearing commences, may influence their procreational and life-planning decisions and prevent disease transmission to future generations.

Now we get into stormy waters. How do we protect the rights of people who are doomed to develop a disease like Huntington's or who are at significant risk for a potentially lengthy, disabling – and costly – malady? If their employers know, will they suffer job discrimination or termination, or insurance cancellation? These real concerns may prevent people from getting tested because of possible adverse social and financial repercussions even if they know a genetic disorder, with latent serious consequences, runs in their family. Thus, potential lifesaving monitoring or early interventional techniques may be bypassed. As gene therapy becomes more accessible, proven and widespread, this issue will become of greater import.

Insurance companies are likewise concerned that individuals who discover they are at serious risk for a devastating illness will buy huge life insurance policies under false pretenses or without disclosing such information. There are some legal protections for insurers, but they vary widely in scope from protecting insurers who don't provide coverage to preventing inquiry about the results of genetic tests or denying coverage based on genetic information.

People who are not responsible for their genetic makeup shouldn't be punished for something they can't change, according to Edison Liu, MD, a cancer researcher at the University of North Carolina in Chapel Hill. As our scientific horizons expand, so do the ethical and practical questions about treating this information wisely and justly. Wendy McGoodwin of the Council for Responsible Genetics called the debate over genetic testing the "civil rights issue of the next century." I'd say she's right, and we have to be there marching along with our patients.

GUEST EDITORIAL

You can still invest, hurry!

By Edward Fesco, MD

'The sky is falling, the sky is falling' - Chicken Little

For months, you've been reading stories in Illinois Medicine about the Illinois Medical Physician Services Organization Inc. - about how it has been organized and is being capitalized by physicians for physicians. Maybe you even attended one of the statewide meetings where the Illinois Medical PSO and the stock offering were discussed in detail, but you figured you'd have plenty of time to invest later. The time has come to write that check. The deadline for buying stock in the Illinois Medical PSO is Oct. 19 - just a little more than a week away.

Whether we like it or not, in this information age, health care is being controlled by those who control information - mostly insurance companies and hospitals. When the Illinois Medical PSO is capitalized, it will offer its physician clients an independent, objective source of managed care information - clinical, financial and demographic data - to help us reassert our control over our patients' care. But that can be done only if we first capitalize the PSO. Let's face it, the sophisticated services the PSO plans to make available are beyond the scope of most local physician organizations and

small practices. Making investments in our own markets is a good start, but only our collective investments in the Illinois Medical PSO will give us all an opportunity to tap into the resources we need and wouldn't otherwise have. Our future requires our united efforts to fund a pro-physician organization.

Some physicians may be wondering, What exactly will the PSO do for me? If you use its services, the PSO will provide data on the outcomes of various procedures performed in your office to help you become as efficient as possible. It will evaluate your patient base, fee schedule, expenses and opportunities for practice expansion and help you make your practice more attractive to managed care purchasers. By working with the PSO, physicians can develop the clinical information to make their current contracts more profitable and negotiate better future contracts.

You should also know that the services provided by the Illinois Medical PSO will be customized to meet the specific needs of each physician client, and those services will be provided by experts who understand physicians' concerns and priorities. The PSO will place

primary emphasis on the goals of doctors - not those of insurers, hospitals or other nonphysician groups. But unless investors buy enough stock in the PSO, none of this can become a reality.

You are eligible to buy stock in the Illinois Medical PSO if you are an Illinois resident and are licensed to practice medicine in Illinois or have voluntarily surrendered your license to practice. With physician stockholders, the company will always be directed by physicians. The purchase price is \$1,000 per share, and a minimum investment of five shares of voting-preferred stock is required. Investors who make that minimum pur-

chase can buy up to 10 more shares of nonvoting-participating preferred stock.

This is your last chance to invest in your profession at a time when we are being "gobbled up." Unlike Chicken Little, we do not have to follow Foxy-Loxey to his den.

The Illinois Medical PSO must have your support to go forward. For more information or to get subscription documents, call (888) ISMS-PSO or (312) 551-2377 today!

Dr. Fesco is a general surgeon in LaSalle and chairman of the Illinois Medical PSO Board of Directors.

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Yohimbine HCl

Description: Yohimbine is a 3 α -15 α -20 β -17 α -hydroxy Yohimbine-16 α -carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth.

Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic α -2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to α -2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by β -adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however, no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patients sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral α -adrenergic blockade. These include anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

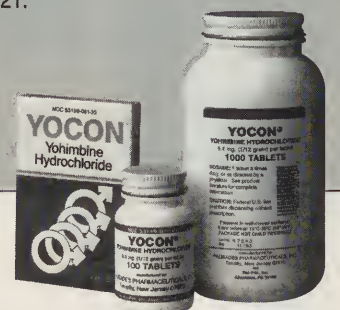
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence:^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage is to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01, 1000's NDC 53159-001-10, and blister-paks of 30's NDC 53159-001-30.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman - The Pharmacological Basis of Therapeutics 6th ed., p. 176-188, McMillan.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. December, 1984.



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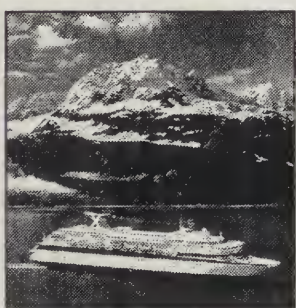
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Wednesday, October 23, 1996	Vivian M. Dickerson, M.D. Los Angeles, CA	<u>Rudolph Holmes Memorial Lecture</u> Women's Health Care in the XXI Century
Wednesday, November 20, 1996	Sharon L. Dooley, M.D. Northwestern University	<u>Augusta Webster Memorial Lecture</u> Screening for Gestational Diabetes
Wednesday, January 15, 1997	Karl C. Podratz, M.D. Mayo Medical School	<u>James E. Fitzgerald Memorial Lecture</u> Molecular Medicine
Wednesday, February 19, 1997	David A. Grimes, M.D. University of California San Francisco, CA	<u>Rudolph Holmes Memorial Lecture</u> Evidenced Based Medicine
Wednesday, March 19, 1997	<u>Chairman's Research Awards</u>	
Wednesday, April 16, 1997	Washington C. Hill, M.D. Perinatal Center Sarasota Memorial Hospital Sarasota, FL	<u>President's Lecture</u> Where Are We Now in the Early Detection of Preterm Labor and Prevention of Preterm Birth?
Wednesday, May 21, 1997	<u>Resident Paper Awards</u> Annual Business Meeting	
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7:00 p.m. Dinner
8:00 p.m. Program

Northwestern establishes new level of outpatient care

[CHICAGO] Northwestern Memorial Hospital in Chicago has established a new clinical level of care for outpatients who are recovering from certain surgeries or tests and need extra time to recover from an anesthetic or adjust to pain medications but don't need a higher level of observation care.

"This new level of patient care, called Outpatient II, enables physicians to admit outpatients to a bed for extended recovery from six to 12 hours," said Wilson Hartz, MD, a general surgeon and chairman of the executive utilization committee that developed the program. "In most cases, the patients we've admitted to Outpatient

II need to stay in the hospital overnight but do not need the high level of care and monitoring every two hours that is required for observation care."

Since the inception of Outpatient II about six months ago, about half of Northwestern's patients who would have been admitted into observation care have been designated for the new-level care instead. Patients who are most likely to qualify are those who have undergone hernia repairs, gallbladder operations, lumpectomies with axillary dissections, mastectomies and orthopedic procedures like anterior cruciate ligament repair, according to Dr. Hartz. ■



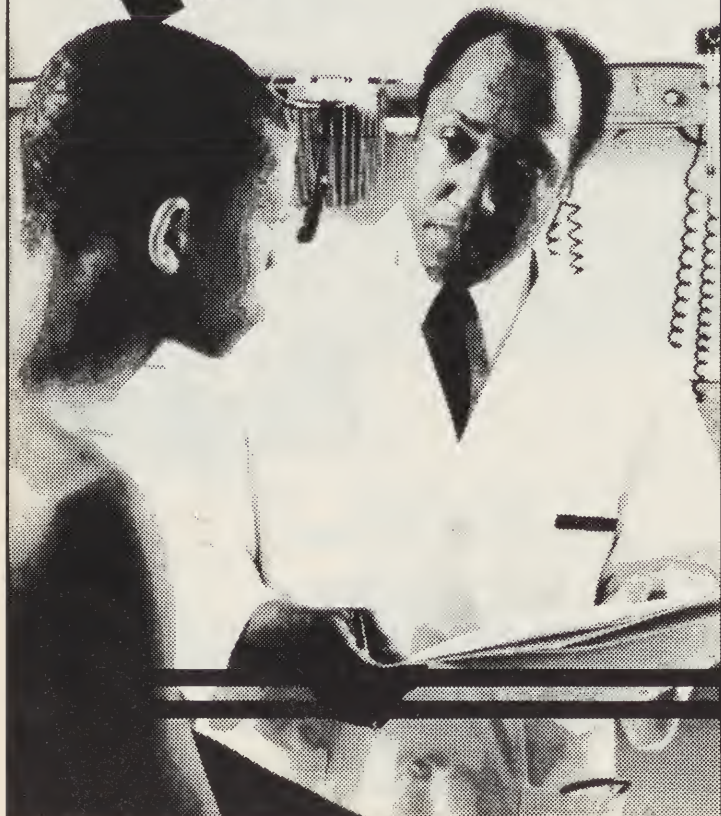
ISMS to hold physician leadership symposium in November

Physicians can learn more about the tools they need to create and lead a successful organization in a managed care environment at the ISMS-sponsored "The Fundamentals of Physician Leadership: A Symposium on Physician-Driven Health Care Organizations." The program will be held Nov. 2 in Oak Brook.

Jeff Goldsmith, president of HealthFutures, will deliver the keynote address on physician leadership. Other speakers will discuss information systems that meet physicians' needs; patient loyalty in a managed care marketplace; income distribution and compensation; legislation, liability and antitrust updates; and utilization control through patient empowerment. A question-and-answer session will also be included.

The symposium is free and will be held from 9 a.m. to 4:45 p.m. at the Marriott Oak Brook Hotel, 1401 W. 22nd St., Oak Brook. For more information, call (800) 782-ISMS.

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ISMIE Update

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Maintaining patient confidentiality

Physicians and their office staff should be careful when releasing or discussing information about patients.

BY KATHLEEN FURORE

Most physicians get calls, letters, subpoenas or other correspondence daily requesting information from their patients' records. Although communicating patients' health history and status might seem innocuous, doctors and their staff should be cautious about the release of such information, according to defense attorneys.

Information about HIV tests and mental health problems, for example, shouldn't be dispensed without a special release signed by the patient, according to attorney Pat Foltz of Chicago's Lord, Bissell & Brook. "You often see reports on HIV and psychological tests in the office records. Some doctors don't realize those records are subject to a separate privilege. Even the fact

that an HIV test was done or ordered falls under that privilege. Confidentiality statutes require [that physicians get] something beyond a regular release or subpoena."

Electronic communication can also compromise patient confidentiality, especially since there is no way to confirm that the patient, not another party, will receive the message. Consequently, physicians and their staff should not leave messages about test results and other specific health information on a patient's voice mail or answering machine or send it by fax "unless the patient specifically requests it," Foltz said. E-mail, too, is off-limits, since someone other than the patient may have access to the patient's password, she added.

"You shouldn't leave messages at [the patient's] work or home if you're not positive the message is accessible only to your patient," Foltz said. "You don't know what patients want family members to know." She noted that doctors and other health care providers "technically can't talk to anyone without the patient's permission."

"Occasionally, I've seen a case where a husband is ill and thinks his wife is too frail to know," Foltz continued. "You don't want the doctor to say to the wife, 'Your husband's cancer is going to be treated with...'" The only person you should talk to about the patient's well-being is the patient. If the family inquires, say you have to make sure the patient gives permission. There's no need to get it in writing. It's OK to have just an oral disclosure."

Physicians and staff should handle third-party requests for information about a patient with extreme caution. Foltz said she recalled an incident in which someone called the hospital to check on the condition of a car accident victim: "The driver [of the car that hit the victim] called the hospital unit and said he was a family member. I think people are trying to find out what happened [to the patient] and what they might be sued for."

"If Jane Smith's father-in-law calls to ask what's wrong, tell him to have Jane call and tell the office that it's OK to tell," said attorney Kevin Glenn of Bresler, Harvick & Glenn in Chicago. "That kind of communication covers more than half the cases of improper release of materials that come up."

DISCUSSING PATIENTS in hallways, on elevators or in any other public place is another potential problem. "[Physicians and staff] can describe a factual scenario but make it vague enough so that the patient can't be identified," Glenn said. Physicians



often consult their peers about medical conditions and treatments, he noted, adding, "I think that's good medical care, and the majority of doctors do this well and take the steps necessary not to identify the patient to whom they're referring."

Physicians aren't the only ones who could breach patient confidentiality, however, Glenn explained. "The inappropriate release of information in patients' records is almost universally a glitch in an office procedure. That's why I suggest that doctors develop a written policy that gives a simple explanation of what patient confidentiality entails. When you hire someone, say, 'This is one of the rules we live by.' When you give staff their tax forms, give them a copy of the policy. It all comes down to good communication."

Orthopedist Richard Geline, MD, chairman of ISMIE's Risk Management Committee, said his office gives out patient information only with a release from the patient. Since he has a "one-horse" practice, he said, "nothing goes out that does not go over my desk. If there is an improper request, it stands out glaringly. No release, no information."

Dr. Geline said he considers three groups of people to be appropriate recipients of patient

information. The first, of course, are patients or their designees. The second includes professional colleagues "with a need to know," but the information provided to them should be "confidential and sanitized," he said. In the third group are third-party payers "within the bounds of propriety. They have the right to know what they're paying for. They have the right to know exactly what the diagnosis is, what the CPT code is. You can't just say, 'Pay up and don't ask questions.'"

Foltz cautioned that doctors must get a release from a patient before giving information to third-party payers. "The release usually is included on the claim form. But that release doesn't cover HIV, mental health or drug and alcohol information." Physicians are prohibited by law from releasing any information related to the treatment of a mental health condition by a physician, a psychologist, a social worker, a nurse or anyone who has treated or dealt with a patient's mental health problem, Foltz explained. "Doctors must follow the same rules with insurers as they do with anyone else. And they still need authorization and a special release for HIV and mental health information." ■

ISMS Physician Assistance Committee to hold 'First Step' conference in Peoria

This month, ISMS' Physician Assistance Committee will hold the first of what may become an annual conference for Illinois physicians recovering from chemical dependency and their families and friends. Called "A First Step," the program will take place Oct. 25-27 in Peoria and will allow attendees to share their experiences with other recovering doctors and to learn more about chemical dependency and its effects on health care professionals.

By attending, physicians can also earn four hours of Category 1 CME credit toward the AMA Physician's Recognition Award. ISMS is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME activities for physicians.

Specific topics included in the program are the causes of addiction, the disease

model for addiction, the effects of co-dependency on the disease process, the influence of chemical dependency on health care professionals and their families, the similarities between the disease model of addiction and psychoanalytic thinking, the role of spirituality in the recovery process, women's special treatment needs and gender-specific roles in recovery.

The program will be held at Jumer's Hotel & Lodge in Peoria. The registration fee is \$90 per person (\$180 per couple) for ISMS members and \$100 per person (\$200 per couple) for nonmembers. The fee covers meeting materials, CME certificates, two breakfasts, one lunch, one banquet and coffee breaks.

To get more information or a registration form, call the Physician Assistance Committee at (312) 782-1654 or (800) 782-4767.

Digging up the past in Bosnia

Chicago pathologist works around the world on human rights activities.

BY CHRIS PETRAKOS



AP Photo/Staton R. Winter

Robert Kirschner, MD, of Chicago, stands in an old sewing factory east of Tuzla, Bosnia, surrounded by bags containing war crimes evidence exhumed from mass graves. Dr. Kirschner is working through the group Physicians for Human Rights to perform autopsies for the International War Crimes Tribunal.

For Dr. Robert Kirschner, a typical day in Bosnia begins at 6 a.m., one of the only times when there's enough water to take a shower. It usually ends about 16 hours later, with a good-night call to his wife in Chicago. In between, he performs the slow, grueling task of sorting through the piles of bodies dug up from one of the many mass graves scattered throughout the war-torn countryside.

Dr. Kirschner, a former deputy medical examiner for Cook County, spent most of August in Tuzla, overseeing the forensics team that is gathering evi-

dence of war crimes for the International War Crimes Tribunal for the former Yugoslavia. Dr. Kirschner retired from the medical examiner's office in April 1995 because, he admitted laughingly, "my job was interfering with my extracurricular activities. And I found these activities much more interesting."

He has been involved in human rights work since 1985 when he traveled to Argentina to assist in the exhumation and identification of the "missing" – citizens who had vanished during that country's brutal reign of terror by the military. Since then, he has traveled to Guatemala, Kuwait, Rwanda, Israel and other

areas where human rights violations have taken place. Most of that work has been under the auspices of Physicians for Human Rights, a 10-year-old, Boston-based organization that was formed specifically to apply the skills of the medical profession to the documentation of human rights abuses and humanitarian law. "Civil liberties has always been a concern to me," said Dr. Kirschner, who is the director of PHR's forensics program. "I think it's an opportunity to use the moral influences that physicians still have throughout the world to take stands on human rights issues."

The organization first became involved in Bosnia following the human massacre near Vukovar, a particularly infamous episode of the war. Wounded Croatian soldiers and medical staff were removed from the Vukovar hospital via its back exits "literally as the Red Cross was standing at the front door." They were taken in buses to a nearby farm, where, after being beaten for several hours, they were shot and buried in a mass grave outside the town of Ovchara.

The incident gained notoriety in large part because it represented the epitome of a war crime: soldiers violating the medical neutrality of a hospital, Dr. Kirschner explained. "This has a great impact on us as physicians. Operating in a war theater or in a place where there is conflict, we have to be guaranteed our neutrality to carry out our responsibilities as physicians. We have to be able to treat wounded people without regard to which side they were fighting for, and we have the right to be respected by all sides as long as we are performing our humanitarian actions within the prescribed rules of international law."

Not surprisingly, the process of exhumation and body identification is a slow one. Once a grave site is confirmed, anthropologists exhume the bodies, recovering any identifiers and evidence of causes of death, including clothing. If the bodies are skeletons, all the parts are collected and taken to a lab for examination. In this case, the laboratory is an abandoned clothing factory in Tuzla where nearly 30 people work to identify the bodies and the causes of death. At the site are four autopsy tables, radiology equipment and a complete computer lab so that data can be entered immediately. "I like to emphasize the efficiency of our work," Dr. Kirschner said. "It's often stated that the cost of an autopsy here in the United States is about \$1,000. Our costs in Bosnia are between \$2,000 and \$2,500. But considering that we have to bring everybody in from overseas, set up our own facilities, buy our own vehicles to transport people back and forth and buy our own water purification system, I feel like we have a remarkable system."

DESPITE THE TERRIBLE FATE of the victims, the autopsies are not technically challenging — unless remains are commingled because bodies were dumped on top of one another in the grave, Dr. Kirschner said. The extensive skeletal-system damage caused by high-velocity gunshot wounds can also make the reconstruction of injuries very time-consuming.

Skeletal remains are usually easier to work with than remains with intact soft tissue, because the bones can be laid out and put back together, Dr. Kirschner explained. No one, he added, likes to work with decomposed bodies. "But from the point of view of understanding the injuries, it's actually better if the bodies still have soft tissue. That way the bone and the bone fragments are held in place, and it's easier to determine the trajectory of bullets — and to differentiate post-mortem from ante-mortem injuries. It's hard, for instance, to look at a fractured rib in a skeletized remain to know whether it's an ante-mortem injury or it's something that's occurred from the pressure of the earth. Those of us who have done hundreds of autopsies on exhumed bodies are fairly good at making that

kind of determination, but it's still better if you have a body that has soft tissue, where you can look for signs of hemorrhage or other indications that these are ante-mortem injuries."

One of the most troubling aspects of his work is dealing with the survivors, Dr. Kirschner said. "After a while, the number of bodies just becomes overwhelming, and there's almost a feeling of monotony at the sight of the dead. But I think harder still is hearing what has happened to the people and their families. That's much more difficult than dealing with the bodies themselves."

Identifying the dead is a monumental, frequently impossible task. The mass grave in the Srebrenica region alone holds 6,000 to 7,000 dead. PHR can exhume only what is requested by the tribunal, which is a few hundred bodies; the rest of the exhumations are performed by local groups. But in an attempt to assist in the identification of the dead, the organization has established an office in Tuzla and trained 30 interviewers to go to refugee centers for information.

IN THE BEGINNING, Dr. Kirschner estimated that only 5 to 10 percent of those missing would be identified. But he and his colleagues have discovered that the survivors have an extremely good recollection of the clothing their loved ones were wearing when they were last seen. "Keep in mind, these were people who had been cut off from access to consumer goods for several years. Many of them were very poor and made their own clothes. So a man's wife or his mother would have handled his one shirt many, many times, and she would have intimate knowledge of the buttons and threads. They can give very vivid descriptions of the clothing. And we've found that there is enough uniqueness in the clothing that we can actually do better than what I originally estimated."

The identification of all bodies will never be fully accomplished, but Dr. Kirschner's group hopes to gather enough evidence for the prosecution of war crimes. To that end, PHR's work raises the question: How many bodies does it take to determine whether a crime has taken place? "One," answered Dr. Kirschner. "If I have one person whose hands are bound behind their back, and they've been shot in the head, then a crime has been committed. But it's a good question. We actually went to some effort to determine statistically what kinds of numbers were needed and what kind of sampling should be used if you get into a grave with a thousand people and you don't want to exhume the whole grave."

The issue, he insisted, is not at all academic. The passage of time and the lack of evidence have allowed historical revisionists to deny the existence of atrocities like the Holocaust. Similar attempts have already begun in Bosnia, creating the need for mountains of painstakingly collected data.

The bleakness of the situation in Bosnia has not shaken Dr. Kirschner's conviction that physicians working in the area of human rights can effect change: "Next week, I'll be going out to Washington to meet with the representative of the Palestinian authority about torture in Palestinian jails. In two years, there have been seven deaths in custody at Palestinian jails. Human rights groups have been putting a lot of pressure on Palestinian authorities about this. One reason I was asked to go down there is that I had spent many years going over to Israel investigating deaths of Palestinians in Israeli custody. So I feel I have some credibility in going to the Palestinians and saying, 'Look, we protested when the Israelis were doing it to Palestinians. You can't turn around and do the same thing.' And in areas like that, I do feel that we've made progress with some countries. But it goes slowly." ■

Medical-society

(Continued from page 1)

to cost-effective health care and to not have [them] change their existing patient-physician relationships and their existing patient-hospital relationships, which is what was happening."

Lance said PMSCO approaches local physicians who are interested in forming managed care entities or who want their existing entities to become more active players in the managed care market. "We help them to go operational. We develop them or convert them, and then we give them the tools," Lance said.

Those tools include information systems. The company provides the sophisticated computer systems needed to deal with managing numerous managed care plans, each with different requirements and payments structures, Lance said. PMSCO's fees vary according to the tools and services provided in the packages, which are tailored to fit the needs of each physician organization.

Dr. West said his PO has 175 stockholders and is still offering stock. PMSCO provided support to develop the PO by forming the committees that run it, helping those committees function and doing basic paperwork.

Lance said that after the POs are up and running, PMSCO also negotiates risk arrangements and capitated contracts between the physicians and the payers.

Physician leadership is the reason the local POs have succeeded, Lance said. "We just provided the expertise for the physician leadership."

Most of the physician organizations PMSCO develops are multispecialty models, with about 35 to 40 percent of their physicians in primary care and 60 to 65 percent in specialties, Lance said. The governance of the POs is majority primary care, he said, which helps the physicians market themselves to man-

aged care plans. They are also generally for-profit professional corporations, allowing for hospital and pharmacy surpluses to be redistributed to physician members. Only physicians are allowed to own shares, and each physician is allowed to purchase only one share. PMSCO does not own any portion of the local physician organizations.

"These entities do protect physicians in their existing models and allow them to move into a mature managed care market without having to turn their lives upside down," Lance said. "An awful lot of people try to convince physicians that managed care eliminates solo practices. I began to convey to them that 10 years into a mature managed care market in Riverside [California] where I was, 50 percent were still in solo practice."

Lance said that PMSCO expected to have between 12 and 14 POs around the state at this point in their operations, but the demand for the company's services has exceeded expectations: "We have 32 POs representing close to 6,500 physicians in this state."

Dr. West said forming a PO and contracting with PMSCO has enabled physicians to negotiate better fees with managed care companies. "Our ability to negotiate with them was zero in a six-person group," said Dr. West, referring to his local practice. "When we contacted the managed care companies we work with and said, 'Hey, we haven't had a fee increase in five years,' they just sort of laughed and said, 'Well, I guess we should look at it and consider reducing them.'"

Now physicians have more clout in negotiating appropriate reimbursement.

Dr. West said his PO chose PMSCO because of the physicians' favorable experience with the Pennsylvania Medical Society and its medical malpractice insurance company. The insurance company's good reputation gave participating physicians the confidence that PMSCO would operate similarly. "I would strongly encourage the physicians in Illinois to set up their own managed services organization," he said. "This is one more way for physicians to take back control."

Illinois Medical PSO

(Continued from page 1)

uled to expire on Oct. 19. "This is the last opportunity for Illinois physicians to invest in their own future by purchasing stock in the Illinois Medical PSO," said Edward Fesco, MD, chairman of the Illinois Medical PSO Board of Directors.

The PSO, which will be owned and operated by physicians, aims to help physicians participate in managed care on their and their patient's terms. To ensure the company always remains physician-directed, only Illinois physicians who are licensed or have voluntarily surrendered their license to practice medicine may buy stock. The purchase price is \$1,000 per share, and a minimum investment of five shares of voting-participating preferred stock is required. Investors who make the minimum purchase can buy up to 10 additional shares of nonvoting-participating preferred stock.

A program will be held on Tuesday, Oct. 15, in conjunction with a Peoria Medical Society meeting for physicians who are interested in learning more about the PSO. Call (888) ISMS-PSO or (312) 551-2377 for more information on the meeting, the stock purchase or the Illinois Medical PSO.

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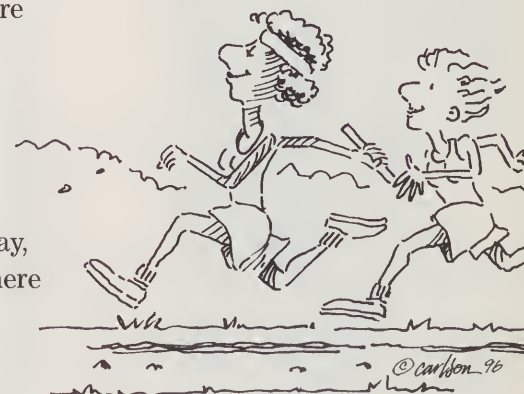
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New federal antitrust

(Continued from page 1)

trust statements, networks were legal only if they accepted capitation, withheld substantial physician fees unless certain utilization parameters were met, or communicated contract terms between the physicians and payers through a third-party messenger system. All other physician networks risked being tagged for illegal price-fixing by the federal government.

Now federal officials will let doctors form fee-for-service networks and other ventures that don't assume insurance risk, provided the entities produce clinical or functional integration – through the use of practice parameters and utilization review – that benefits patients.

Although the federal agencies don't precisely define the terms, they do provide examples of acceptable ways in which networks can create "efficiencies," according to attorney Edward Hirshfeld, the AMA's vice president of health law. Networks could create efficiencies, for example, by developing practice parameters and utilization pro-

grams, carefully selecting network physicians and requiring significant capital investment from doctors.

According to Hirshfeld, the kinds of fee-for-service networks that are now legal are those that operate under a "messenger model" that is more streamlined than was allowed in the past; use utilization review programs to control costs and assure quality; negotiate a discounted fee schedule with payers, agree on a predetermined budget and use rewards and/or penalties to motivate network physicians to meet or exceed budget targets; and negotiate arrangements with payers to withhold substantial physician fees unless certain parameters are met.

The new guidelines will allow physicians in small and medium-sized practices to form simple networks that do not require experience in assuming and managing risk. "It is now more likely that specialists in rural and Downstate areas, for instance, can set up systems and be more viable," Morse said.

"Under the old guidelines," said Hirshfeld, "the only kinds of networks that were legal were those that accepted capitation or substantial fee-withholds. It

takes a lot of investment in management systems to develop that kind of network, and it takes experience in managing risk to operate them successfully.

"Small and medium-sized practices frequently do not have the experience or access to the capital necessary to develop and operate these networks," Hirshfeld continued. "However, these practices can now form fee-for-service networks that require less investment and less experience to operate."

Morse gave an example of how the change would affect some physicians: "For larger groups of independent physicians, the new guidelines mean they could establish a network to provide good prices and good-quality orthopedic service to all the insureds of a health plan. Up until now, they could negotiate with the managed care plans only as individuals. One of the potential benefits of the new guidelines is that physicians will now be able to negotiate in larger numbers. That strength puts them on a more equal footing with the big networks."

The guidelines do, however, require fee-for-service networks to prove that they have a management infrastructure that's capable of generating efficiencies and that the infrastructure is being used.

The broad range of fee-for-service networks addressed by the new guidelines is also important to large groups that want to expand their specialty and geographic coverage by contracting with independent physicians. The guidelines say that networks can exceed the previously established safety-zone size limits, but they do not specify the amount by which they can exceed them and still be safe from antitrust prosecution.

According to the 1994 guidelines, the safety zones for exclusive ventures were less than 20 percent of doctors in a specialty in a particular market, and for nonexclusive ventures, the limit was 30 percent. To qualify, networks were required to take on "substantial risk" through capitation or substantial fee-withholds. After discussions with the FTC and the DOJ, the AMA said it believes nonexclusive networks operating in competitive markets can now include

as many as 50 percent of physicians in a given market and still be legal. The new guidelines do not specifically address the issue of group practices or networks that want to expand across state lines.

In addition, large group practices that have contracted with independent physicians can now form a network that offers both a capitated product for HMOs and a fee-for-service product for PPOs, according to Hirshfeld. However, any network that accepts both must demonstrate that it is using its management infrastructure to generate efficiencies for both the capitated business and fee-for-service business.

Group practices that require their members to deliver all the health care provided by those groups do not have to be concerned about this distinction, Hirshfeld said. "Because they are fully integrated groups of physicians, they can engage in joint negotiations over price and other terms with payers. The new guidelines are for physicians who are in independent practice and who are not permitted to engage in joint negotiations over fees and other terms unless they follow the guidelines." But when these group practices want to extend their specialty or geographic coverage through arrangements with independent physicians, the groups must apply their management systems to the independent physicians when negotiating for fee-for-service business, Hirshfeld said.

"The real thrust of these guidelines is to open up new opportunities for physician networks that make them competitive with health care delivery networks organized by others," Hirshfeld concluded. ■

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AMA surveys physicians on managed care

To help identify physician concerns about managed care, the AMA and Hewitt Associates have developed a survey asking physicians for their opinions of the managed care plans in which they participate. On Oct. 4, Physician's Health Plan Assessment Surveys were mailed to 100,000 physicians in 22 markets across the country, including Chicago and northern Illinois. In those markets, 50 percent of the primary care physicians and 50 percent of the specialists who were most likely to have participated in managed care were randomly selected from AMA records to receive the survey.

ISMS encourages Illinois physicians who have received the survey to complete and return it by the Nov. 1 deadline. All responses will be kept confidential.

According to the AMA, many surveys have monitored patients' satisfaction with their health plans, but physicians haven't been asked their views of plans. The AMA will use the survey results as a basis for advocating that health plans address areas of greatest concern. Hewitt Associates will also distribute the survey results to more than 300 Fortune 500 companies that collectively cover more than 18 million employees. The AMA anticipates that the companies will use the information when they evaluate health plans and make purchasing decisions.

State will sue

(Continued from page 1)

tion's Office on Smoking and Health. Researchers determined the public health costs of smoking by examining factors for each state such as smoking prevalence, population and incidences of tobacco-related diseases, said Patrick McSteen, a public policy analyst for the state lung association.

"We applaud the attorney general for trying to make [members of] the tobacco industry further aware that they and their attorneys are the only people in the world who believe cigarettes don't cause diseases," said Samuel S. Gidding, MD, chairman of the Illinois Coalition Against Tobacco. That organization, led by state and regional heart and lung associations, coordinates the anti-tobacco efforts of more than 100 health care institutions, advocacy groups and community organizations.

*The tobacco industry
and its attorneys
are the only people in
the world who
believe cigarettes don't
cause disease.*

"All citizens actually pay for tobacco-related illnesses whether it's through the use of tax dollars for Medicaid or through their own insurance premiums," said Dr. Gidding, who is an associate professor of pediatrics and preventive medicine at Chicago's Northwestern University Medical School and an attending cardiologist at Children's Memorial Hospital in Chicago.

"Any help that we as physicians can give Jim Ryan is certainly available," added Stan Bugaieski, MD, president of the American Lung Association of Central Illinois and treasurer of the American Lung Association of Illinois. "States are certainly justified in addressing [tobacco] issues by suing for those costs related to paying for Medicaid recipients who have diseases produced by various types of tobacco use," said Dr. Bugaieski, who is also director of regional services at St. Francis Medical Center in Peoria.

Ryan said he expects to file the lawsuit in the near future. The legal theories used to recover smoking-related health care costs from the tobacco industry will be detailed then, he said. A team of local and national law firms will be chosen to assist with the case, and those chosen will bear most of the litigation's costs, he added. The state is also exploring other funding options to limit the amount of taxpayer funding spent on the lawsuit.

With his announcement about the lawsuit, Ryan also proposed new state legislation that would place stricter limits on the sale of tobacco products to minors. State law now prohibits the sale of tobacco products to people under age 18, but Ryan cited research that shows the law isn't effective much of the time. National studies, for instance, show that minors succeed in buying cigarettes over

the counter in 73 percent of attempted purchases, and the seller doesn't ask for proof of age in 78 percent of all such transactions. Illinois studies have shown that minors are successful in 60 percent of their attempts. "We cannot continue to allow this highly addictive product to flow almost unhindered from stores to their young hands," Ryan said.

If approved, the new law would require Illinois retailers and wholesalers to obtain a license to sell tobacco. They would face license revocation, penalties and fines if caught repeatedly selling tobacco products to minors, Ryan said. The proposed legislation would impose a

\$500 fine for the first offense, a \$1,000 fine and a six-month license suspension for the second offense, and a \$1,000 fine and a license revocation for the third offense within 12 months. Minors who purchased, possessed, smoked or chewed tobacco or used snuff tobacco would face a \$500 fine, 100 hours of community service and/or participation in an education program, Ryan said.

"We strongly support legislation to keep tobacco products out of the hands of minors," Dr. Olson said. Studies have shown that people greatly reduce their chances of smoking if they don't begin before or during their teen-age years,

she added.

Other provisions of the legislation would require merchants to post signs to inform customers of the law and provide a toll-free telephone number to report illegal sales, would permit the operation of cigarette vending machines only in places where minors are prohibited and would ban the sale of unpackaged cigarettes. The legislation would also aim to curtail cigarette shoplifting by eliminating the sale of tobacco products from open, self-service displays.

Ryan said the legislation will be introduced to the Illinois General Assembly in November. ■

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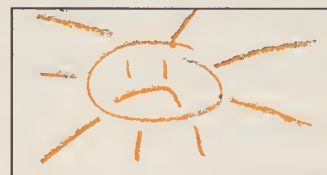
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Conference urges physicians to tackle oral, pharyngeal cancers

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • OCTOBER 25 1996



Billboards draw
a picture of
child abuse

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PARAMEDICS and hospital medical staff triage volunteer victims during a Sept. 28 disaster drill at O'Hare International Airport. After the "disaster" of two mocked-up wide-body aircraft colliding and a subsequent fire, victims were triaged and sent to five area hospitals.



Bob Kusel for the MCHC

IDPA files rules for MediPlan Plus

REFORM: Rules will become final after 45-day comment period that began Oct. 11. BY JANE ZENTMYER

[SPRINGFIELD] The Illinois Department of Public Aid in October formally released the proposed rules for implementing its Medicaid reform program, MediPlan Plus, said George Hovanec, IDPA's director of medical programs. The rules, which were filed with the secretary of state's office, will become final following a 45-day comment period that began Oct. 11, Hovanec said. They, as well as IDPA's protocol detailing how MediPlan Plus will be set up internally, will be forwarded on Nov. 1 to the U.S. Health Care Financing Administration for review and comment.

MediPlan Plus was designed

to improve health care delivery to the state's Medicaid recipients and to control costs through managed care. In July, HCFA granted the state a waiver that allows program implementation. The waiver grants permission to IDPA to assign to managed care providers those recipients who fail to select a provider, to lock enrollees into their chosen or assigned provider for one year and to permit the development of Managed Care Community Networks, which will contract directly with IDPA. MCCNs are managed care entities that provide or arrange for primary, secondary and tertiary health

care services, but unlike HMOs, they may treat only MediPlan Plus enrollees.

Eligible recipients will receive a mailed form asking them to choose one of the following: a fee-for-service primary care physician, a Federally Qualified Health Center, a Certified Pediatric Ambulatory Care Center or a rural health clinic, all of which would function as a gatekeeper, or a managed care entity such as an HMO, an MCCN or a Prepaid Health Plan. Those exercising their option of choosing a fee-for-service primary care physician can write the doctor's

(Continued on page 15)

Congress, president approve benefit expansion

REFORM: Patients with mental illnesses and moms and babies will gain. BY DEBORAH PREISER

[WASHINGTON] After U.S. House and Senate negotiators agreed on the Mental Health Parity Act of 1996 and the Newborns' and Mothers' Health Protection Act of 1996, President Bill Clinton signed both measures on Sept. 26. The mental health act gives Americans who experience severe depression, schizophrenia or other mental illnesses a better chance of having related medical treatments covered by their employee insurance and health plans. The new law, however, allows insurers to impose some limitations, doesn't provide complete parity of coverage for mental and physical illnesses and exempts busi-

nesses with fewer than 50 employees. U.S. Rep. Dennis Hastert (R-14th District), who chairs the House health care reform task force, was a chief negotiator on both pieces of legislation. He termed the mental health measure "a compromise everybody can live with."

The health protection act guarantees the option of 48-hour hospital stays for all new moms and their babies after a vaginal delivery and 96-hour hospital stays after a cesarean section. The law signals an end to "drive-through deliveries," the practice adopted by some managed care plans that sends

(Continued on page 14)

Ryan announces plan to curb domestic violence

STATE INITIATIVE: Intensive training for emergency department professionals is part of new program.

BY DEBORAH PREISER

[CHICAGO] Illinois Attorney General Jim Ryan held news conferences in Chicago, Springfield and Rockford on Sept. 12 to outline his three-point plan to deter domestic violence in Illinois. "Domestic violence is one of the most underreported crimes in Illinois and one of our most serious public safety and public health problems," Ryan said. "Women are being victimized across the state, and we must do more to protect them."

Ryan cited statistics: "In Illinois, 97 percent of the victims of domestic violence are women. Studies indicate that between 22 and 35 percent of women who visit emergency departments come because they have been beaten. Of women who are victims of homicide, 42 percent are killed by an intimate partner."

"This issue requires a paradigm shift," Ryan continued. "We can no longer view domestic violence as just a law enforcement problem." Ryan intends for his plan to facilitate that paradigm shift. It will include a pilot program to train health care professionals who work in emergency departments to identify, screen, treat and refer victims of domestic violence. In addition, Ryan will propose a new law in the spring 1997 legislative session to make it a crime for offenders to interfere with victims' ability to report acts of domestic violence. And finally, 400 law enforcement agencies will be provided with Polaroid camera kits to document domestic violence crime scenes and injuries.

Also on Sept. 12, Ryan
(Continued on page 8)

Physicians should help break cycle

[CHICAGO] The time has come for emergency department health care providers to look beyond physical injuries and ask open, nonjudgmental questions to identify and help victims of domestic violence, according to Carole Warshaw, MD. At the September conference sponsored by the attorney general's office, ISMS and other organizations, Dr. Warshaw addressed representatives of emergency department hospital teams.

Abuse is not always an easy issue for physicians to raise, Dr. Warshaw said. "Listening to women describe the violence that brought them to the hospital makes doctors deal with painful issues," said Dr. Warshaw, who is board-certified in internal medicine, emergency medicine and psychiatry. "Most are not trained in psychology and are uncomfortable with the feelings of pain that are raised."

Yet the problem is widespread enough to warrant physician involvement, and many physicians have the opportunity to get involved, Dr. Warshaw said. "Between 21 percent and 25 percent of all women will experience violence from an intimate partner in

(Continued on page 8)

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Salvi, Durbin
vie for U.S.
Senate seat

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DEPARTMENTS

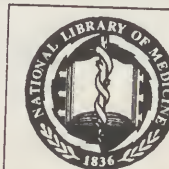
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PROPERTY OF THE
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MEDICINE

Violence Prevention Yellow Pages available to physicians

PUBLIC HEALTH: Guide lists services, experts, print resources.

BY DEBORAH PREISER

[CHICAGO] Growing up in Williamsport, Penn., home of the Little League, Robert Smith, MD, knew little of violence. But working at Cook County Hospital's trauma center for the past 10 years has changed that. Dr. Smith spends many hours patching up the bodies of young gang members: "The kids who are getting shot are getting younger and younger while the firearms on the street get more powerful. Five to seven years ago, it was unusual to see a kid shot multiple times. Now with the 9-mm

semiautomatic handguns on the street, it's just the opposite," said Dr. Smith, who serves as director of the hospital's Division of Pre-Hospital and Prevention for the Department of Trauma.

Frustrated by this trend, Dr. Smith joined John Barrett, MD, director of the hospital's trauma center, and several other colleagues to form the Chicago Area Violence Prevention Project in 1991. Through their collaboration, the doctors began to look at violence as a disease and to study its etiology as well as its treatment.

Last year, with support from the Chicago Department of Public Health and the Cook County Bureau of Health Services, the doctors created the Violence Prevention Yellow Pages, a comprehensive resource directory that catalogs hundreds of area services, ranging from male-aggression discussion groups to tattoo-removal programs that help former gang members get rid of gang symbols.

In early September, the Chicago Department of Public Health volunteered to publish an additional 500 copies of the Violence Prevention Yellow Pages, and the Cook County Department of Office Automation offered to include the entire directory on its Internet home page, which should be available at <http://www.co.cook.il.us> by late 1996.

The idea for the directory came when the doctors discovered that dozens of violence prevention programs existed throughout Illinois. But often these programs were not coordinated, and many of the families and professionals who needed the services had no way of knowing about their existence. "We recognized that all kinds of people — physicians, attorneys, law enforcement and public health officials — as well as community-based organizations, can play a role," Dr. Smith said. "Our goal was to

provide a working document that can aid in the collaboration and coordination of all those working in the area of violence prevention."

The directory is "meant to be a work in progress," and a three-ring-binder format was chosen to allow users to copy pages and add information easily, he explained. Forms are included so that users can suggest additions and send them by fax to Dr. Smith for inclusion in future editions.

With Linda Murray, MD, medical director at Winfield Moody Health Center in Chicago, Dr. Smith compiled an epidemiology section that incorporates many charts and studies related to violence. In this section, the authors note that guns account for almost 70 percent of all homicides and that in 1993, handguns were used in more than 80 percent of all firearm-related homicides.

The directory also lists experts available to speak on violence and school-based violence prevention programs, as well as books, magazine articles, videos and other materials available to physicians, schools and parents.

For more information on the Chicago

Area Violence Prevention Project and the Yellow Pages, call the CAVPP offices at (312) 409-3616. ■



SHARON SPAK-SCHREINER, MD (right), unravels some of the mysteries of X-rays to student Wendy Jovel (center) as Carla Toppen, RN, looks on. The women participated in Health Careers Night Oct. 2 at Lutheran General Hospital in Park Ridge.

ISMS symposium to focus on leadership

ISMS is sponsoring a symposium that will cover what physicians need to know to become leaders in managed care. The program, "The Fundamentals of Physician Leadership: A Special Symposium on Physician-Driven Health Care Organizations," will be held Nov. 2 in Oak Brook.

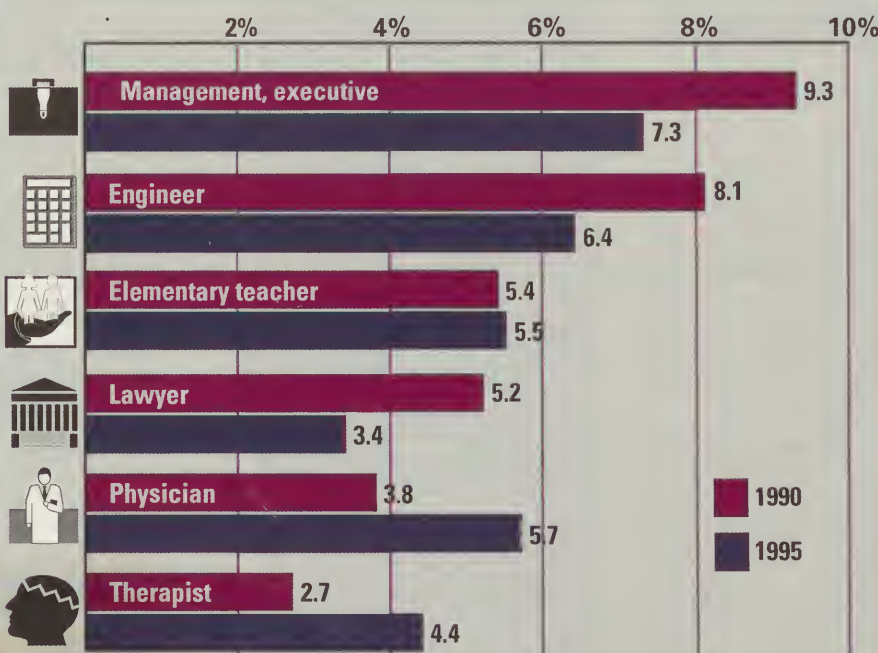
Speakers addressing the symposium's theme of physician leadership will include Jeff Goldsmith, PhD, president of HealthFutures; Carlton Pearse, MD, president of Generations Health Care; and Carl Getto, MD, dean and provost of the Southern Illinois University School of Medicine. In addition, several sessions will focus on specific applications for physicians: designing an information system that meets changing needs, building patient loyalty in a managed care marketplace, exploring income distribution and compensation, and controlling utilization through patient empowerment. ISMS President Sandra Olson, MD, will participate in an update on antitrust laws, legislation and liability.

The program's goals are to help physicians identify opportunities for greater economic and organizational leadership, determine elements of practice organizations that need strengthening, recognize when managed care program requirements are unacceptable and learn how to negotiate more favorable contracts.

Physicians who attend the symposium can earn seven credit hours in Category 1 of the Physician's Recognition Award of the AMA. ISMS is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME activities for physicians.

The symposium is free for ISMS members and \$100 for non-members and will be held from 9 a.m. to 4:45 p.m. at the Marriott Oak Brook Hotel, 1401 W. 22nd St., Oak Brook. For more information or to register, call (312) 782-1654 or (800) 782-ISMS.

Career choices for first-time college freshmen, 1990 and 1995



Source: Cooperative Institutional Research Program, University of California at Los Angeles

Time is short to renew your medical license

Physicians who fail to renew their medical licenses in October will face serious consequences. The grace period expires at the end of the month, and any physician who does not have a new three-year license then will be practicing medicine without a license. Possible penalties include fines and disciplinary action by the state Medical Disciplinary Board. In addition, most medical malpractice insurers, including ISMIE, lapse coverage for the time physicians practice without a valid license.

Physicians who have not renewed their license must immediately send their completed renewal forms, along with full payment, to the Illinois Department of Professional Regulation. For physicians renewing now, a \$100 late fee applies. The cost of a standard three-year, in-state renewal, including the late fee, is \$400; out-of-state renewals are now \$700 with the late fee. Physicians may contact the department at (217) 782-0458 to request forms but should allow ample time for mailing and processing.

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Salvi, Durbin vie for U.S. Senate seat

GENERAL ELECTION: On Nov. 5, voters will decide which candidate replaces Sen. Paul Simon. BY JANE ZENTMYER

[CHICAGO] This fall's race for the U.S. Senate seat open in Illinois features two candidates whose positions on issues important to physicians could influence the success of physician-friendly legislation in the U.S. Congress, particularly the passage of federal tort reform. Voters who cast their ballots in the Nov. 5 general election can choose Republican Al Salvi or Democrat Richard J. Durbin to replace the retiring U.S. Sen. Paul Simon.

Salvi won the GOP nomination for the U.S. Senate after a come-from-behind victory over Lt. Gov. Bob Kustra in the primary. Salvi, from Wauconda, is an attorney who was first elected an Illinois state representative in 1992 and who resigned earlier this month. While in the state legislature, Salvi served on several committees including environment and energy, elections and state government administration, and judiciary. Durbin, an attorney from Springfield, was first elected to the U.S. House of Representatives in 1982. He is a member of the appropriations committee and the ranking minority member of the subcommittee on agriculture and rural development.

Both candidates completed Illinois Medicine questionnaires, which show divergence on an issue important to physicians: caps on noneconomic damages. Salvi indicated that he supports a \$250,000 federal cap on noneconomic damages; Durbin wrote that he does not.

Although Salvi voted "present" on the state tort reform bill in 1995, which included a \$500,000 cap on noneconomic damages, his vote reflected his concerns about provisions related to punitive damages in product liability cases, he said at a Sept. 29, 1995, press conference. "I support a \$250,000 cap on noneconomic damages," he said on the questionnaire.

Salvi also said he backs other tort reforms including "a modified English rule where the plaintiff could be liable for the cost of a lawsuit if he files a frivolous lawsuit" and a reform that requires "a defendant to pay only that portion of noneconomic damages that corresponds to his or her degree of responsibility for the injuries." Salvi indicated he also supports the current limitations on attorneys' fees in Illinois and a statute of limitations that requires medical malpractice lawsuits to be brought within two years for an adult and nine years for a child.

Durbin voted against HR 956, which would have imposed a \$250,000 federal cap on noneconomic damages, according to the April 8, 1995, issue of the Congressional Quarterly Limited. Tort reforms supported by Durbin include "the establishment of alternative dispute resolution processes, a requirement that a lawyer obtain a 'certificate of merit' from a doctor stating that the care

received was substandard before a lawsuit can be filed, and reasonable limits on the percentage of an award that will be devoted to attorneys' fees," according to the questionnaire. These reforms are already in place in Illinois.

Durbin co-sponsored the ill-fated Clinton health care reform proposal. But on other health-related issues, Salvi and Durbin hold similar positions. Both can-

didates said they support several managed care reforms, including eliminating gag clauses, preventing managed care plans from retaliating against physicians who advocate care for their patients, requiring managed care plans to notify patients when their physicians are terminated from the plans and standardizing the utilization review that determines approval or denial of requests for care, according to the questionnaires. "Congress should set basic standards to ensure that quality is not lost in the race to the bottom line and give patients the assurance that their doctors are putting their patients' needs first," Durbin said.

Although the questionnaire was sent to the candidates prior to passage of federal antitrust reform legislation, both expressed their support for antitrust relief that would allow physicians to form their own networks and compete with insurance and managed care companies. "Quality medical care is best protected by a plurality of health care systems," Salvi said. "Physician-led networks can provide health care alternatives to insurance and managed care companies, but antitrust relief is essential to this process."

Both Salvi and Durbin also support restrictions on the tobacco industry to protect children and teen-agers. ■



Salvi



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REPORT for Illinois Physicians

What Happens to Medical Policy?

Last issue we shared our process for the development of medical policies at Blue Cross and Blue of Illinois (BCBSI). If life was only that simple....

Although BCBSI looks like an Illinois Company serving local employers, patients and doctors, our customers often have employees across the United States. Ameritech and Jewel Stores are two (2) such examples. It is important to them, their employees, and their unions that patients are treated consistently wherever they receive care. To achieve this end, our physicians work collaboratively with others from other Blue Cross Blue Shield Plans to achieve consistency in our policies. The task is daunting. We encounter few troublesome issues when dealing with most major procedures and diagnoses (e.g. CABG, Immunizations, HIV/AIDS), but must work diligently to achieve consistency in dealing with new, emerging, or non-traditional types of care. For example:

- When reviewing infertility centers-of-excellence, is pregnancy defined as "a take home baby", or as increasing hormonal markers in the potential mother?
- What's a referral: from one doctor to another doctor, from one doctor to any other place for any type of service, or from one doctor to another doctor or for a service which can be rendered only by a physician?
- What is "non-traditional care" and how is it reimbursed?
- When is a treatment no longer considered experimental?

In Illinois, we rely on you, comprising expert peer panels, to help us work through these and many other issues. Other states do likewise. BCBS physicians then meet and agree on the most reasonable approach to these and similar issues. Underlying these decisions we hold true to several principles:

1. The treatment or technology must have final approval from the appropriate government regulatory body, if appropriate;
2. The treatment or technology must be supported by scientific evidence that permits conclusions concerning the effect of the treatment on health outcomes;
3. The treatment or technology must improve the net health outcome;
4. The treatment or technology must be as beneficial as any established alternatives;
5. The treatment or technology is available outside of investigational settings;
6. The treatment or technology is adjudicable in most instances from the claim information, minimizing the need to request additional medical information from you.

We will continue to rely on the expertise and understanding of physicians throughout Illinois and, as necessary, throughout the nation. We continue to work toward the ideal where we adjudicate claims consistently in all circumstances for all patients.

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EDITORIAL

Making a difference

This summer Northwestern University's Medill School of Journalism and television station WTTW released a poll about why Americans don't vote and shattered some stereotypes. Most nonvoters are not poorly informed Neanderthals, according to the survey results published in the Chicago Sun-Times. Half of the nonvoters questioned said they watched TV news six or seven times per week, and one-fourth said they read a newspaper that often.

The largest nonvoting group, 29 percent, was called "doers," people involved in the community and interested in politics. Next came the "irritables," individuals who were angry at the government and felt their votes didn't count. The third-largest group, the "unplugged," knew little about public affairs and were ambivalent about politics. Then came the "don't knows," who were out of touch, and finally the "alienated," who were not just out of touch but also angry at the government because of its perceived ineffectiveness.

Although the groups varied, a common thread was the opinion that voting isn't necessary or doesn't make any difference. But it is, and it does.

Remember the 1994 general election? Thanks to the 53 percent of registered voters who actually voted – and perhaps the 47 percent who failed to vote – Illinois Republicans captured enough seats

to win the majority in the Illinois House, which had been under Democratic control for 12 years. The GOP in the Senate increased its majority by one seat. That meant Republicans controlled the General Assembly and the governor's seat for the first time since 1971. After the election, a spokesperson for Gov. Edgar said, "It's clear that meaningful tort reform will have the best chance in decades of being approved by the General Assembly." That prediction became a reality a few months later, when Edgar signed tort reform into law.

Clearly, the 1994 election brought significant change for all Illinoisans. And in 1996, we're at the same threshold, only now we're trying to preserve tort reform. Through challenges to the law and the introduction of bills in the General Assembly, efforts have been made to reverse our progress. As a result, we still need tort reform supporters in the Statehouse.

Candidates' views on managed care are also important. That's why IMPAC sent a questionnaire to candidates asking them their positions on many managed care-related issues. To get information about candidates who returned their questionnaires, you can call IMPAC at (312) 782-1963.

The outcome of races in key House and Senate districts will help determine our future. Your vote will make a difference.

PRESIDENT'S LETTER

'All politics are local'

Sandra F. Olson, MD



The races that affect us the most in our daily lives are really the local ones.

Another election is quickly coming upon us. You can't turn on a television set, listen to a radio or drive down a highway without being beset by campaign commercials for local and national candidates. Some races capture our attention much more than others. The presidential contest always garners intense national publicity. The national news shows endlessly speculate, discuss and interview anyone with an opinion – it's a constant round of rotating musical chairs that never cools off. The newscasters are doing their best to spark the nation's interest after the ho-hum reception people gave the conventions and after a lackluster debate that was predictable.

But the races that affect us the most in our daily lives are really the local ones – in our own school districts and townships and for state and national assemblies. These can be exciting and hard-fought rivalries, especially because the candidates are often well-known in the community, and not just faces in the media. But how many people really take an interest, study the issues and try to make informed choices? Sadly, not enough. Only about 53 percent of registered Illinois voters cast their ballots in the 1994 general election, according to the state Board of Elections. And many eligible citizens never even registered. Although there were problems in the recent election in Bosnia, almost all the eligible voters cast their vote – in fact, many endured physical hardships to do so. They didn't take their own electoral privilege the least bit lightly. So why do we? The United States was founded on the principle that the majority of voters, not just an eligible elite, have the inalienable right to choose their leaders and those so empowered are answerable to the electorate. Countries that have abjured that principle haven't fared well lately, so that's an important lesson for us as they fight for free elections. Here we are in a country that was founded on

this philosophy, but we citizens don't execute the responsibility. John Quincy Adams said, "Where annual elections end, there slavery begins." On Oct. 6 on "Face the Nation," Ross Perot said, "The future of this country lies with the people if they will just grasp it." His words are true. We don't know the potential power we have. If doctors expressed their choices to legislatures in only matters related to health care and motivated their patients to do the same, who knows what the outcome would be for our nation's turbulent health care system?

We need to support candidates who protect quality health care. Since the Illinois legislative races will determine many of these issues for the citizens of Illinois, why not get involved? If we lose legislators who are friendly to medicine, what will happen to tort reform? Will the laws be reversed? Illinois Sen. Dave Syverson (R-Rockford) emphasized how physicians need to be involved when he cited their help in educating him and the importance of hearing physicians' opinions on health-related issues.

Candidates truly want to hear the opinions of their constituents. They know who put them in office, and they know who can remove them. They take voting power very seriously. So why don't we? Is it because we take it for granted? Is political activism anathema because we don't want to get involved or stand up and be counted? Unfortunately, for many, the only time they want to participate is when they are threatened, and that is often too late. The time for us is now. We cannot be complacent when the state legislature is concerned. And if you have a favorite candidate, consider a tangible show of support: host a coffee, send a personal contribution or at least contribute to IMPAC. We must protect the gains we've won. And above all, vote on Nov. 5.

GUEST EDITORIAL

Your vote counts!

By Richard A. Jorgensen, MD

Reprinted from In Brief, published by the DuPage County Medical Society, Copyright 1996.

"MY VOTE DOESN'T MATTER."

Too often physicians who manage the most complex medical care in the world absolve themselves of the social and political obligations to vote.

"AFTER ALL, I'M TOO BUSY."

Tort reform was voted into law last year by getting out the votes.

"POLITICIANS ARE ALL THE SAME."

The election process is long, confusing and difficult for the electorate. We lose interest in the election rhetoric. The candidates and their platforms seem to blur through the 30-second sound bites and made-for-TV commercials. We think, "I don't really understand the process. I can't distinguish one candidate from another. I won't bother to vote."

"ALL THEY WANT IS MY MONEY."

We are so inundated with requests for political and charity contributions that

we reach the point of slamming down the phone before listening to the message. Electing good politicians will always cost money. We cannot allow candidates who are friendly to medicine to die on the vine because of lack of funding.

The Illinois Medical Political Action Committee was developed to help the individual practitioner with these concerns. Because the process of electing good candidates is difficult and expensive, the collective evaluations and contributions made through IMPAC can be used to support those candidates who best support the ideals of medical care.

IMPAC was created by the Illinois State Medical Society to get more people to vote on medical issues, to identify candidates who are knowledgeable and friendly to physicians' issues and to pool funds as a means to elect good politicians into office.

IMPAC is a nonpartisan, not-for-profit committee run by members from various districts around the state. I am the DuPage County representative on this council. We meet regularly and evaluate each of the candidates on the federal and

state level. If there is a need, smaller local elections are evaluated at the suggestion of the interested member.

IMPAC spends 100 percent of the money it receives on electing candidates who understand the complexities of providing quality medicine with the changing legal and insurance landscape.

"SHOULD I VOTE? WHOM SHOULD I VOTE FOR? HOW DO I CONTRIBUTE TO THE RIGHT CANDIDATE?"

Recent statistics reveal that only 25 percent of physicians vote in the general elections. Only about 50 percent of physicians residing in DuPage County are members of the DuPage County Medical Society, and only 40 percent of DCMS members contribute to IMPAC. These statistics may help us understand why medical issues may be on the back burner for politicians and why we may have a difficult time making our voices heard.

IMPAC needs to be made stronger with more physicians willing to participate in the election process. Those who learn the system, participate in the system and vote in the system are the system. If every physician – together with his or her spouse, children, neighbors and friends – votes, we can be a substantial bloc. If every physician can also influence his or her siblings, aunts, uncles, cousins and office staff and their families, the medical profession will have

created a voting bloc to be reckoned with. Every vote counts. Some very important elections have been decided by less than 5 percent of the voters.

*Why not work together
to elect the right people
for medicine?*

The medical profession, as a political interest group, must critically discern the positions of the candidates. Those candidates whose views are consistent with ours are much more likely to become legislators who will support our positions while in office. These candidates are deserving of our financial support and our utmost efforts to get out every vote we can.

As constituents of IMPAC, we must act as loyal members of the political group we seek to become. We must support and vote for the candidates who support the positions advocated by physicians regardless of other positions or opinions these candidates may hold.

Whether or not you vote, candidates will be elected, and those elected will run the system. Why not work together to elect the right people for medicine?

Dr. Jorgensen is a member of the IMPAC Council.

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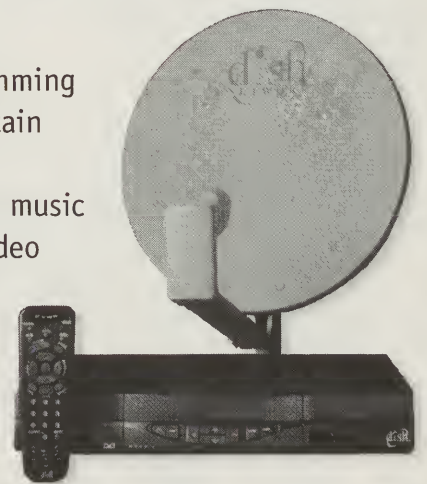
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ISMIE Update

Taking an extra step with medical histories

Corroborating patient information and asking open-ended questions are good risk management techniques.

BY RICK PASZKIET

Patients' medical histories offer physicians a wealth of vital information. Yet the reliability of information provided by patients may be questionable, so it's up to physicians to ensure that those histories are accurate and complete. "Providing good patient care requires medical histories that the doctor can trust," said Herb Sohn, MD, a urologist at the University of Chicago/Weiss Memorial Hospital. "The physician can never assume that the medical information patients provide is correct. You have to go the extra step to ensure reliability," he added.

That extra step requires "obtaining a patient's medical records from other physicians and hospitals for verification, as well as taking the time to question the patient about his or her own medical history," Dr. Sohn explained.

According to Dr. Sohn, studies have shown that patients typically give their physician a verbal medical history in 16 seconds. Contributing to the problem is that patients are sometimes asked to respond to questions with only a yes or no. To gather the maximum amount of relevant information, physicians should ask open-ended questions, even if it takes more time.

"Sometimes the physician has no choice but to ask probing and difficult questions to verify the patient's information," said Dr. Sohn, who teaches physician-patient communication at Finch University of Health Sciences/The Chicago Medical School. Even though taking patients' medical histories has always been a part of the curricula for medical students and residents, the emphasis today is on helping physicians improve their

overall communication skills including history-taking, he explained.

"You have to listen to what the patient is saying — without any interruptions," Dr. Sohn said. "For instance, the physician should never direct a patient's answers. Let patients describe their medical histories in their own words. Some of this information may be already written down on a medical history form, but keep in mind that these forms tell only part of the story. That's why it's so important to question the patient to get a more complete medical history."

A complete and accurate patient medical history serves another important function: It provides written documentation that can help reduce physician liability. "When done properly, medical histories act as independent witnesses," said Tim Nickels, a partner with the Chicago law firm of Wildman, Harrold, Allen & Dixon. "They greatly reduce the likelihood of claims being filed. However, if a patient's medical history is inaccurate, and the doctor made no attempt to verify the information, a potential risk management problem can exist."

Nickels stressed that patients' medical histories should extend



beyond the information listed in a standard medical history form. Physicians should demonstrate that they have scrutinized patient records and that there are no omissions or inconsistencies in it. "The physician must corroborate the patient's medical history, and if something does seem suspicious, the physician has no choice but to do a more in-depth analysis."

TO COMPLICATE MATTERS, patients may ask physicians to omit certain information from their medical histories or records. For instance, they may not want their medical histories to show that they've used anti-depressant drugs, because that information could be an issue with insurers or employers. How should physicians respond?

"I've never been directly involved in a situation where a patient has asked me to omit something from his or her med-

ical record, but physicians have to be extremely cautious when faced with this type of request," said Dr. Sohn, who is also an attorney. "Let's assume a patient doesn't want it revealed that he or she is on anti-depressants. What would happen if the general practitioner's partner treats the patient, and this information is not included in the record? It could present serious repercussions."

"In this case, the best course for the physician is to educate the patient on the importance in having a thorough and accurate medical history," Dr. Sohn continued. "Patients need to understand how their medical histories are used."

Nickels said that from a risk management standpoint, the content of patients' medical histories should not be dictated by patients. Rather, physicians should determine what information can and cannot be omitted.

"Overall, physicians do an excellent job in taking medical histories," Nickels said. "Most doctors are sensitive to the risk management issues posed by inaccurate medical histories. The goal is to go beyond the standardized medical form and gather as much information as possible about the patient." ■

Seminar to focus on risk management for breast cancer



Over the past few years, lawsuits alleging failure to diagnose breast cancer have increased dramatically. To help physicians understand the issues involved in breast cancer claims and use procedures to help prevent them, ISMIE is again offering the seminar "Failure to Diagnose Breast Cancer: A Case Study." It will be held from 8 a.m. to noon on Nov. 16 at the Inland Meeting and Exposition Center in Westmont.

The program includes a mock trial and panel discussion and explains the most common allegations in breast cancer litigation, clinical issues in screening for and diagnosing breast cancer, and risk management techniques related to diagnosis and treatment.

Led by moderator David Cromer, MD, chairman of the ISMIE Ob/Gyn Risk Management Subcommittee, seminar speakers include Daniel Crane, MD, radiologist; John Knaus, DO, Ob/Gyn; Eileen Murphy, MD, Ob/Gyn; Gerald Zatuchni, MD, Ob/Gyn; and Chicago-based attorneys Richard Donohue of Donohue, Brown, Mathewson & Smyth and David Hall of Lord, Bissell & Brook.

The cost is \$50 per person for ISMIE-insured physicians and their staff and \$100 for all others. For seminar registration information, call the ISMIE Risk Management Division, (312) 782-2749 or (800) 782-4767.

MALPRACTICE ROUNDUP

Child born with cerebral palsy awarded \$35.6 million

A New York jury awarded \$35.6 million to a child born with cerebral palsy, allegedly caused by oxygen deprivation during a delayed delivery, according to the Sept. 2 edition of the National Law Journal.

In McDonald vs. Prime, the mother arrived at a Brooklyn hospital in January 1988 to give birth. She had a fever, which indicated the presence of an infection requiring an immediate cesarean section, according to plaintiff attorneys. Instead, the Ob/Gyn induced labor, and the baby was born vaginally, after which she was diagnosed with cerebral palsy.

The jury found the hospital 40 percent liable and the physician 60 percent liable. The hospital settled for an undisclosed amount before the verdict, and the judgment will be reduced, according to the article. ■

Conference urges physicians to tackle oral, pharyngeal cancers

STRATEGY: Oral examinations can help reduce mortality.

BY KAREN TITUS

[CHICAGO] The war on cancer has moved to a new battleground: oral and pharyngeal cancers. The latest attack is being waged by national health care groups, including the Centers for Disease Control and Prevention; the National Institute of Dental Research, which is affiliated with the National Institutes of Health; and the American Dental Association. Meeting in Chicago this summer at a conference sponsored by those organizations, a group of experts outlined strategies for preventing and treating oral cancer. The goal is to reduce morbidity and mortality by the year 2000 by increasing disease awareness among physicians, other health care professionals and the public.

Turning the spotlight on this disease is critical, according to conference participants. "We know a lot about the etiologies; we know the importance of early diagnosis; we understand the problems of primary and secondary prevention and, where necessary, rehabilitation," said conference participant Stephen Corbin, chief dental officer of the U.S. Public Health Service. "But we really haven't made all that much progress" in halting the disease.

Oral and related cancers kill about 8,000 Americans annually and account for some 2 to 4 percent of all cancers diagnosed in the United States, according to the CDC. Despite advances in surgery, radiation and chemotherapy, the five-year survival rate for this group of cancers has improved little in the last four decades, holding at about 53 percent, noted Harold Slavkin, director of NIDR.

Generally included in this category are cancers of the tongue, lip, salivary glands and other sites in the mouth, and the nasopharynx, oropharynx and hypopharynx. More than 90 percent are squamous cell in origin, and patients with oral cancer often exhibit multiple primary lesions, according to background papers from the conference. Patients with primary oral cancer face increased risk of developing cancers of the lung, stomach, esophagus and larynx. The average age at diagnosis is 60, and men are twice as likely to be affected as women, said the reports.

Particularly worrisome are indicators that oral cancer is on the rise in Americans between the ages of 15 and 35. "There has been a threefold increase in oral cancer among young Americans from 1975 to 1991," Slavkin said.

CONFERENCE PARTICIPANTS MADE a strong appeal to physicians and other health care providers to conduct appropriate oral examinations. Said attendee William Lander, MD: "We need to be doing as many oral examinations as the dentists."

Diagnosis often comes late in the game, said Sol Silverman Jr., chairman of the Department of Oral Medicine at the University of California at San Francisco School of Dentistry. "It's a challenge to clinicians to identify that there may be a problem and to create a differential diagnosis. Clinicians often have difficulty in differentiating benign from malignant lesions and recognizing a cancer when

it's in its earliest stages," he said, adding that about two-thirds of oral cancers are diagnosed when the disease is advanced. The problem stems in part from the fact that early oral cancers generally are not highly symptomatic and are rarely painful, he said, making it easy for clinicians to mistake early squamous cell car-

cinoma for either chronic irritation or infection.

Attendees also emphasized the need to reduce tobacco use among patients. "The general public recognizes very strongly that smoking will cause lung cancer, [but] the majority do not know that smoking will cause oral cancers," said Alice Horowitz, PhD, a senior scientist at NIDR's Disease Prevention and Health Promotion Branch. The link between oral cancer and smokeless tobacco is also tenuous in the public's perception. "People still think of spit tobacco as an honest, clean alternative to cigarettes. And it's anything but," said

Rick Bender, an oral cancer survivor.

Reimbursement will be another key factor in the fight, said attendees. Thomas Houston, MD, director of the AMA's Department of Preventive Medicine and Public Health, called for appropriate reimbursement to physicians who work with patients on alcohol, tobacco and other behavioral interventions. "We should reaffirm that the existing codes appropriately identify the oral cancer exam as a component of the standard oral exam and the standard history and physical, and that managed care entities [cover] oral cancer exams as well." ■

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Pregnancy Warning: ACE inhibitors should be discontinued as soon as pregnancy is detected (see Warnings).

Angioedema and cough have been reported in patients receiving ACE inhibitors. Headache and edema are the most common side effects in patients receiving amlodipine.

†Data on file, Ciba.

Please consult brief summary of Prescribing Information on the following page.

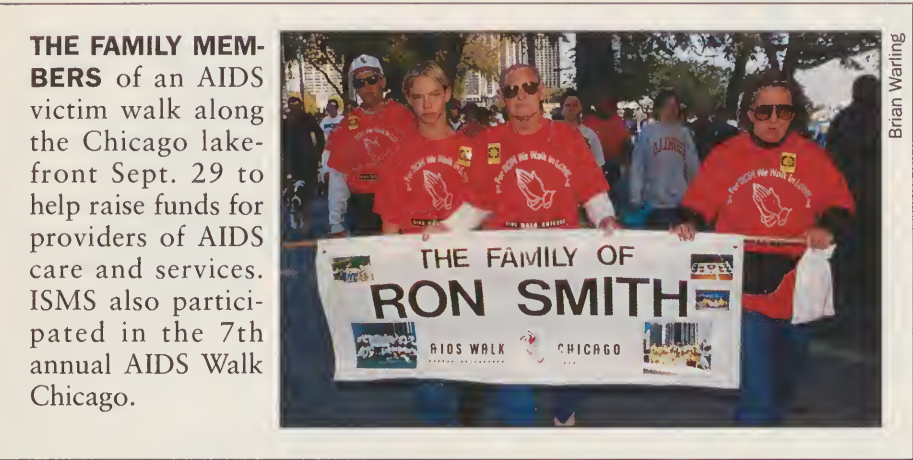


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BRIEF SUMMARY (FOR COMPLETE PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

USE IN PREGNANCY
When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Lotrel should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

INDICATIONS AND USAGE
Lotrel is indicated for the treatment of hypertension.

This fixed combination drug is not indicated for the initial therapy of hypertension (see DOSAGE AND ADMINISTRATION).

In using Lotrel, consideration should be given to the fact that an ACE inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen-vascular disease. Available data are insufficient to show that benazepril does not have a similar risk (see WARNINGS, Neutropenia/Agranulocytosis).

Black patients receiving ACE inhibitors have been reported to have a higher incidence of angioedema compared to nonblacks.

CONTRAINDICATIONS
Lotrel is contraindicated in patients who are hypersensitive to benazepril, to any other ACE inhibitor, or to amlodipine.

WARNINGS
Anaphylactoid and Possibly Related Reactions
Presumably because angiotensin-converting enzyme inhibitors affect the metabolism of eicosanoids and polypeptides, including endogenous bradykinin, patients receiving ACE inhibitors (including Lotrel) may be subject to a variety of adverse reactions, some of them serious. These reactions usually occur after one of the first few doses of the ACE inhibitor, but they sometimes do not appear until after months of therapy.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors. In U.S. clinical trials, symptoms consistent with angioedema were seen in none of the subjects who received placebo and in about 0.5% of the subjects who received benazepril. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with Lotrel should be discontinued and appropriate therapy instituted immediately. When involvement of the tongue, glottis, or larynx appears likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine injection 1:1000 (0.3-0.5 mL), should be promptly administered (see ADVERSE REACTIONS).

Anaphylactoid Reactions During Desensitization: Two patients undergoing desensitization treatment with hymenoptera venom while receiving ACE inhibitors sustained life-threatening anaphylactoid reactions. In the same patients, these reactions were avoided when ACE inhibitors were temporarily withheld, but they reappeared upon inadvertent rechallenge.

Anaphylactoid Reactions During Membrane Exposure: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes and treated concomitantly with an ACE inhibitor. Anaphylactoid reactions have also been reported in patients undergoing low-density lipoprotein apheresis with dextran sulfate absorption.

Increased Angina and/or Myocardial Infarction: Rarely, patients, particularly those with severe obstructive coronary artery disease, have developed documented increased frequency, duration, and/or severity of angina or acute myocardial infarction on starting calcium channel blocker therapy or at the time of dosage increase. The mechanism of this effect has not been elucidated.

Hypotension
Lotrel can cause symptomatic hypotension. Like other ACE inhibitors, benazepril has been only rarely associated with hypotension in uncomplicated hypertensive patients. Symptomatic hypotension is most likely to occur in patients who have been volume and/or salt depleted as a result of prolonged diuretic therapy, dietary salt restriction, dialysis, diarrhea, or vomiting. Volume and/or salt depletion should be corrected before initiating therapy with Lotrel.

Since the vasodilation induced by amlodipine is gradual in onset, acute hypotension has rarely been reported after oral administration of amlodipine. Nonetheless, caution should be exercised when administering Lotrel as with any other peripheral vasodilator, particularly in patients with severe aortic stenosis.

In patients with congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria, azotemia, and (rarely) with acute renal failure and death. In such patients, Lotrel therapy should be started under close medical supervision; they should be followed closely for the first 2 weeks of treatment and whenever the dose of the benazepril component is increased or a diuretic is added or its dose is increased.

If hypotension occurs, the patient should be placed in a supine position, and if necessary, treated with intravenous infusion of physiologic saline. Lotrel treatment usually can be continued following restoration of blood pressure and volume.

Neutropenia/Agranulocytosis
Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients (incidence probably less than once per 10,000 exposures) but more frequently (incidence possibly as great as once per 1000 exposures) in patients with renal impairment, especially those who also have collagen-vascular diseases such as systemic lupus erythematosus or scleroderma. Available data from clinical trials of benazepril are insufficient to show that benazepril does not cause agranulocytosis at similar rates. Monitoring of white blood cell counts should be considered in patients with collagen-vascular disease, especially if the disease is associated with impaired renal function.

Fetal/Neonatal Morbidity and Mortality
ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, Lotrel should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of benazepril as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, benazepril should be discontinued unless it is considered life-saving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention

should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or peritoneal dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Benazepril, which crosses the placenta, can theoretically be removed from the neonatal circulation by these means; there are occasional reports of benefit from these maneuvers, but experience is limited.

Lotrel has not been adequately studied in pregnant women. When rats received benazepril/amlodipine at doses ranging from 5:2.5 to 50:25 mg/kg/day, dystocia was observed with increasing dose-related incidence at all doses tested. On a mg/m² basis, the 2.5 mg/kg/day dose of amlodipine is 3.6 times the amlodipine dose delivered when the maximum recommended dose of Lotrel is given to a 50-kg woman. Similarly, the 5 mg/kg/day dose of benazepril is approximately 2 times the benazepril dose delivered when the maximum recommended dose of Lotrel is given to a 50-kg woman.

No teratogenic effects were seen when benazepril and amlodipine were administered in combination to pregnant rats or rabbits. Rats received dose ratios up to 50:25 mg/kg/day (benazepril/amlodipine) (24 times the maximum recommended human dose on a mg/m² basis, assuming a 50-kg woman). Rabbits received doses of up to 1.5:0.75 (benazepril/amlodipine) mg/kg/day; on a mg/m² basis, this is 0.97 times the size of a maximum recommended dose of Lotrel given to a 50-kg woman.

Similar results were seen in animal studies involving benazepril alone and amlodipine alone.

Hepatic Failure
Rarely, ACE inhibitors have been associated with a syndrome that starts with cholestatic jaundice and progresses to fulminant hepatic necrosis and (sometimes) death. The mechanism of this syndrome is not understood. Patients receiving ACE inhibitors who develop jaundice or marked elevations of hepatic enzymes should discontinue the ACE inhibitor and receive appropriate medical follow-up.

PRECAUTIONS
General
Impaired Renal Function: Lotrel should be used with caution in patients with severe renal disease.

When the renin-angiotensin-aldosterone system is inhibited by benazepril, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure, whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors (including benazepril) may be associated with oliguria and/or progressive azotemia and (rarely) with acute renal failure and/or death.

In a small study of hypertensive patients with unilateral or bilateral renal artery stenosis, treatment with benazepril was associated with increases in blood urea nitrogen and serum creatinine; these increases were reversible upon discontinuation of benazepril therapy, concomitant diuretic therapy, or both. When such patients are treated with Lotrel, renal function should be monitored during the first few weeks of therapy.

Some benazepril-treated hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea nitrogen and serum creatinine, usually minor and transient, especially when benazepril has been given concomitantly with a diuretic. Dosage reduction of Lotrel may be required. Evaluation of the hypertensive patient should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia: In U.S. placebo-controlled trials of Lotrel, hyperkalemia (serum potassium at least 0.5 mEq/L greater than the upper limit of normal) not present at baseline occurred in approximately 1.5% of hypertensive patients receiving Lotrel. Increases in serum potassium were generally reversible. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes.

Patients With Congestive Heart Failure: Although hemodynamic studies and a controlled trial in patients with NYHA Class II-III heart failure have shown that amlodipine did not lead to clinical deterioration as measured by exercise tolerance, left ventricular ejection fraction, and clinical symptomatology, studies have not been performed in patients with NYHA Class IV heart failure. In general, all calcium channel blockers should be used with caution in patients with heart failure.

Patients With Hepatic Failure: In patients with hepatic dysfunction due to cirrhosis, levels of benazepril are essentially unaltered. However, since amlodipine is extensively metabolized by the liver and the plasma elimination half-life (t_{1/2}) is 56 hours in patients with impaired hepatic function, caution should be exercised when administering Lotrel to patients with severe hepatic impairment (see also WARNINGS).

Cough: Presumably due to the inhibition of the degradation of endogenous bradykinin, persistent nonproductive cough has been reported with all ACE inhibitors, always resolving after discontinuation of therapy. ACE inhibitor-induced cough should be considered in the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing surgery or during anesthesia with agents that produce hypotension, benazepril will block the angiotensin II formation that could otherwise occur secondary to compensatory renin release. Hypotension that occurs as a result of this mechanism can be corrected by volume expansion.

Drug Interactions
Diuretics: Patients on diuretics, especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with Lotrel. The possibility of hypotensive effects with Lotrel can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with Lotrel.

Potassium Supplements and Potassium-Sparing Diuretics: Benazepril can attenuate potassium loss caused by thiazide diuretics. Potassium-sparing diuretics (spironolactone, amiloride, triamterene, and others) or potassium supplements can increase the risk of hyperkalemia. If concomitant use of such agents is indicated, they should be given with caution, and the patient's serum potassium should be monitored frequently.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving ACE inhibitors during therapy with lithium. Lotrel and lithium should be coadministered with caution, and frequent monitoring of serum lithium levels is recommended.

Other: Benazepril has been used concomitantly with oral anticoagulants, beta-adrenergic blocking agents, calcium blocking agents, cimetidine, diuretics, digoxin, hydralazine, and naproxen without evidence of clinically important adverse interactions.

In clinical trials, amlodipine has been safely administered with thiazide diuretics, beta blockers, ACE inhibitors, long-acting nitrates, sublingual nitroglycerin, digoxin, warfarin, nonsteroidal anti-inflammatory drugs, antibiotics, and oral hypoglycemic drugs.

In vitro data in human plasma indicate that amlodipine has no effect on the protein binding of drugs tested (digoxin, phenytoin, warfarin, and indomethacin). Special studies have indicated that the coadministration of amlodipine with digoxin did not change serum digoxin levels or digoxin renal clearance in normal volunteers; that coadministration with cimetidine did not alter the pharmacokinetics of amlodipine; and that coadministration with warfarin did not change the warfarin-induced prothrombin response time.

Carcinogenesis, Mutagenesis, Impairment of Fertility
No evidence of carcinogenicity was found when benazepril was given, via dietary administration, to rats and mice for 104 weeks at doses up to 150 mg/kg/day. On a body-weight basis, this dose is over 100 times the maximum recommended human dose; on a body-surface-area basis, this dose is 18 times (rats) and 9 times (mice) the maximum recommended human dose. No mutagenic activity was detected in the Ames test in bacteria, in an in vitro test for forward mutations in cultured mammalian cells, or in a nucleus anomaly test. At doses of 50-500 mg/kg/day (38-375 times the maximum recommended human dose on a body-weight basis; 6-61 times the maximum recommended dose on a body-surface-area basis), benazepril had no adverse effect on the reproductive performance of male and female rats.

Rats and mice treated with amlodipine in the diet for 2 years, at concentrations calculated to provide daily dosage levels of 0.5, 1.25, and 2.5 mg/kg/day, showed no evidence of carcinogenicity. For mice, but not for rats, the highest dose was close to the maximum tolerated dose. On a mg/m² basis, this dose given to mice was approximately equal to the maximum recommended clinical dose. On the same basis, the same dose given to rats was approximately twice

Ryan announces

(Continued from page 1)

kicked off a two-day conference in Chicago that was sponsored by the attorney general's office, ISMS, the Chicago Department of Public Health and nine other organizations. The conference launched the pilot project that will lead to "model response" guidelines to be used by every hospital in the state that deals with possible victims of domestic violence. Addressing emergency department physicians, nurses and administrators from the 12 hospitals that will participate in the project, Ryan said: "You see more

the maximum recommended clinical dose.

Mutagenicity studies with amlodipine revealed no drug-related effects at either the gene or chromosome levels.

There was no effect on the fertility of rats treated with amlodipine (males for 64 days and females for 14 days prior to mating) at doses up to 10 mg/kg/day (8 times the maximum recommended human dose of 10 mg on a mg/m² basis, assuming a 50-kg person).

No adverse effects on fertility occurred when the benazepril/amlodipine combination was given orally to rats of either sex at dose ratios up to 15:7.5 mg/kg/day (benazepril/amlodipine), prior to mating and throughout gestation.

Pregnancy
Pregnancy Categories C (first trimester) and D (second and third trimesters): See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Nursing Mothers
Minimal amounts of unchanged benazepril and of benazeprilat are excreted into the breast milk of lactating women treated with benazepril, so that a newborn child ingesting nothing but breast milk would receive less than 0.1% of the maternal doses of benazepril and benazeprilat.

It is not known whether amlodipine is excreted in human milk. In the absence of this information, it is recommended that nursing be discontinued while Lotrel is administered.

Geriatric Use
Of the total number of patients who received Lotrel in U.S. clinical studies of Lotrel, 19% were 65 or older while about 2% were 75 or older. Overall differences in effectiveness or safety were not observed between these patients and younger patients. Clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Pediatric Use
Safety and effectiveness in pediatric patients have not been established.

ADVERSE REACTIONS
Lotrel has been evaluated for safety in over 1600 patients with hypertension; over 500 of these patients were treated for at least 6 months, and over 400 were treated for more than 1 year.

The reported side effects were generally mild and transient, and there was no relationship between side effects and age, sex, race, or duration of therapy. Discontinuation of therapy due to side effects was required in approximately 4% of patients treated with Lotrel and in 3% of patients treated with placebo.

The most common reasons for discontinuation of therapy with Lotrel in U.S. studies were cough and edema.

The side effects considered possibly or probably related to study drug that occurred in U.S. placebo-controlled trials in more than 1% of patients treated with Lotrel are shown in the table below.

PERCENT INCIDENCE IN U.S. PLACEBO-CONTROLLED TRIALS				
	Benazepril/ Amlodipine N=760	Benazepril N=554	Amlodipine N=475	Placebo N=408
Cough	3.3	1.8	0.4	0.2
Headache	2.2	3.8	2.9	5.6
Dizziness	1.3	1.6	2.3	1.5
Edema*	2.1	0.9	5.1	2.2

*Edema refers to all edema, such as dependent edema, angioedema, facial edema.

The incidence of edema was statistically greater in patients treated with amlodipine monotherapy than in patients treated with the combination. Edema and certain other side effects are associated with amlodipine monotherapy in a dose-dependent manner, and appear to affect women more than men. The addition of benazepril resulted in lower incidences as shown in the following table; the protective effect of benazepril was independent of race and (within the range of doses tested) of dose.

PERCENT INCIDENCE BY SEX OF CERTAIN ADVERSE EVENTS								
	Benazepril/ Amlodipine		Benazepril		Amlodipine		Placebo	
	Male	Female	Male	Female	Male	Female	Male	Female
	N=329	N=431	N=269	N=285	N=277	N=198	N=217	N=191
Edema	0.6	3.2	0.0	0.8	2.2	9.1	1.4	3.1
Flushing	0.3	0.0	0.0	0.7	0.4	2.0	0.5	0.0
Palpitations	0.3	0.5	0.4	1.4	0.4	2.0	0.5	0.5
Somnolence	0.3	0.0	0.4	0.4	0.4	0.5	0.0	0.0

Other side effects considered possibly or probably related to study drug that occurred in U.S. placebo-controlled trials of patients treated with Lotrel were the following:

Angioedema: Includes edema of the lips or face without other manifestations of angioedema (see WARNINGS, Angioedema).

Body as a Whole: Asthenia and fatigue.

CNS: Insomnia, nervousness, anxiety, tremor, and decreased libido.

Dermatologic: Flushing, hot flashes, rash, skin nodule, and dermatitis. There have been rare reports of pemphigus in patients receiving ACE inhibitors.

Digestive: Dry mouth, nausea, abdominal pain, constipation, diarrhea, dyspepsia, and esophagitis. There have been rare reports of pancreatitis in patients receiving ACE inhibitors.

Hematologic: There have been rare reports of hemolytic anemia in patients receiving ACE inhibitors.

Metabolic and Nutritional: Hypokalemia.

Musculoskeletal: Back pain, musculoskeletal pain, cramps, and muscle cramps.

Respiratory: Pharyngitis.

Urogenital: Sexual problems such as impotence, and polyuria.

Other infrequently reported events were seen in clinical trials (causal relationship unlikely). These included chest pain, ventricular extrasystole, gout, neuritis, and tinnitus.

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Monotherapies of benazepril and amlodipine have been evaluated for safety in clinical trials in over 6000 and 11,000 patients, respectively. The observed adverse reactions to the monotherapies in these trials were similar to those seen in trials of Lotrel. In postmarketing experience with benazepril, there have been rare reports of Stevens-Johnson syndrome and thrombocytopenia. Jaundice and hepatic enzyme elevations (mostly consistent with cholestasis) severe enough to require hospitalization have been reported in association with use of amlodipine.

Clinical Laboratory Test Findings
Serum Electrolytes: See PRECAUTIONS.

Creatinine: Minor reversible increases in serum creatinine were observed in patients with essential hypertension treated with Lotrel. Increases in creatinine are more likely to occur in patients with renal insufficiency or those pretreated with a diuretic and, based on experience with other ACE inhibitors, would be expected to be especially likely in patients with renal artery stenosis (see PRECAUTIONS, General).

Other (causal relationships unknown): Clinically important changes in standard laboratory tests were rarely associated with Lotrel administration. Elevations of serum bilirubin and uric acid have been reported as have scattered incidents of elevations of liver enzymes.

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victims than we do. It is critically important that the health care community becomes partners with law enforcement. Without your help, we cannot reduce this kind of violence to women."

The 12 participating hospitals, which, according to Ryan, represent every kind of hospital and locale in the state, are Northwestern Memorial Hospital in Chicago, Rush-Presbyterian-St. Luke's Memorial Hospital in Chicago, the University of Chicago Hospitals in Chicago, Oak Park Hospital in Oak Park, GlenOaks Hospital & Medical Center in Glendale Heights, Sherman Hospital in Elgin, Carle Foundation Hospital in Urbana, Doctors Hospital in Springfield, Rockford Memorial Hospital in Rockford, Herrin Hospital in Herrin, Illini Hospital in Silvis, and Thorek Hospital and Medical Center in Chicago. To develop the guidelines, the hospitals will be paired with local agencies that work with victims of domestic violence, Ryan said.

Anti-domestic-violence advocates across the state have set the pace for curbing this violence against women, Ryan noted. "With a collaborative effort among police, prosecutors and treatment providers, we can make a dent in this serious problem."

Ryan thanked ISMS for being "very instrumental in bringing this conference into being" and introduced ISMS President Sandra Olson, MD. "The doctors of Illinois are thrilled that the attorney general is taking the lead on this issue," Dr. Olson said. "We're the ones who treat the victims. And these are women we don't want to treat - because we want no victims."

The time to train medical personnel to help screen and identify victims of domestic violence is "long overdue," said Tunji Ladipo, MD, a Thorek Hospital emergency department physician who attended the conference. "As health care professionals, we miss it, because we're not trained to ask the right questions. Unless we probe further, domestic violence will continue to be greatly underreported."

Physicians should

(Continued from page 1)

their lifetime. Studies have shown that over 50 percent of women who come to emergency departments as patients have been abused by a partner at some time.

"We have to start to link the issues we see regularly with the possibility that our patient has suffered abuse from her partner. Many women come to us for treatment again and again, before anybody asks her the right questions and recognizes the abuse," Dr. Warshaw said. "By not asking, by not responding, we play a role. We opt for the quick fix. We're not able to integrate long-term vision with short-term care."

While acknowledging that diminishing reimbursements for social and mental health services, limited institutional support and confidentiality issues are "structural barriers" to identifying and aiding victims of abuse, Dr. Warshaw said that physicians "cannot just treat the consequences of violence. We must help prevent future acts of violence from occurring."

Editor's note: The ISMS Alliance offers the video "More Than Words: Responding to Domestic Violence," developed especially for physicians. The video is part of an Alliance program that provides 2 hours of Category I CME credit. For more information, call (312) 782-2099.

Billboards draw a picture of child abuse

ISMS Alliance highlights anti-violence community efforts at its fall conference.

BY JANE ZENTMYER



Motorists traveling in Illinois this month saw more than just commercial advertisements littering the landscape. More than 30 of the state's roadside billboards carried a simple message generated by the ISMS Alliance: "Save our children from domestic violence."

Designed with bright colors and a childish scrawl, the billboards are part of an Alliance campaign to encourage more education and community involvement in curbing domestic violence, particularly child abuse. The billboard initiative was timed to begin in October, which is Domestic Violence Awareness Month, and to date, billboards have been placed primarily in Winnebago, Peoria and Marion-Clinton counties.

"We hope that people will see [a billboard] and that it will get them to look at the issue a little closer

and be more aware of what's going on in their own families, with their neighbors and with anyone that they might be associated with," said Janet Rauhaus, president-elect of the Peoria Medical Society Alliance. "Then maybe [they will] intervene whether it's on a personal level or through activities to stop this."

The billboard campaign ties into the AMA Alliance's anti-violence campaign called SAVE — Stop America's Violence Everywhere. Kicked off in October 1995, the AMA Alliance's initiative highlights the medical community's ef-

forts across the country to raise awareness of and fight domestic violence.

ISMS Alliance members discussed the problem and ways to get involved with prevention and intervention during their fall conference, "Offer a Helping Hand, Not a Hurting Hand," held Sept. 26 in Mt. Vernon. Specifically, they learned about the progress of the statewide billboard campaign, the risk factors that lead to domestic violence, the efforts of a Downstate center to combat child abuse and tips for com-

munity involvement.

The need for intervention can certainly be substantiated statistically. According to the Illinois Coalition Against Domestic Violence, a nonprofit, independent advocacy group, programs to combat domestic violence in Illinois provided a variety of services to more than 35,400 Illinois women and 10,300 children during fiscal year 1996. More than 7,000 women and 8,200 children were given overnight shelter, but another 7,000 women and 10,000 children had to be turned away because of a lack of available beds.

The cost of medical care necessitated by domestic violence also poses a problem, according to the coalition. When questioned about insurance coverage to help with those expenses, about 7 percent of women surveyed during FY '96 reported they received only Medicaid coverage; 21 percent received both Medicaid and other public aid coverage; and 22 percent had no insurance.

Effective prevention depends on identifying the risk factors that increase the odds of domestic violence. Some of those factors are a parent who was abused as a child, the lack of a support structure, a lack of education, a job loss, substance abuse and stress caused by problems such as the premature birth of a child or a child born with disabilities, according to Gail Gauen, an Alliance member who works with the Springfield-based Parenting Skills Resource Center. The center was developed by some members of the Sangamon County Medical Society Alliance.

TO HELP WOMEN and children who face those risk factors, there are abundant resources that can be tapped for community programs, said Pat Graham, an Alliance member and president of the Parenting Skills Resource Center. For example, the center can provide pamphlets answering questions commonly asked by new parents and listing organizations that offer classes in childbirth, prenatal care and parenting. The center also makes available a slide show about countering firearm violence that was developed by the group Physicians for Social Responsibility. "It's all there," Graham told conference attendees. "You don't have to start from scratch."

Most anti-violence groups lack the funds to send volunteers or staff to training programs, Graham said.

(Continued on page 10)



Graham

Christina Macias

Billboards draw

(Continued from page 9)

So, she and her colleagues are developing video programs that will offer training and curricula for parenting and anti-violence classes in communities. "I see it as being especially good for the rural areas because they don't have these services," she said.

The recipients of such services get rewards beyond personal safety. Mothers, for example, can get a shot of self-esteem, gain prenatal and parenting knowledge and receive emotional support, Gauzen said. But volunteers also benefit from using their skills and developing new ones, building a sense of camaraderie and experiencing personal growth and satisfaction, she said.

SUPPORTING ABUSED CHILDREN is the focus of the Williamson County Child Advocacy Center in Herrin, which opened in 1992. The center combats child sexual abuse by providing crisis intervention, making referrals for follow-up care and prosecuting offenders, said Kathy Schimpf, the center's executive director. It also provides support groups for nonoffending parents and siblings, she added.

Follow-up advocacy services are provided for an average of six months per case, according to background material from the center. One of the center's two professionally trained advocates maintains at least monthly contact with the child and his or her family.

To date, the center has worked with 248 victims of childhood sexual abuse ranging in age from 2 to 17 years, said the center's background information. An additional 299 siblings of those victims have also received help.

The center, one of 17 of its kind across the state, coordinates various services — law enforcement, the state's attorney's office, governmental agencies and counseling — that assist children who have suffered sexual abuse, said Schimpf. The idea is that these groups can work together to offer better and more complete services to children, she explained.

Schimpf cited the following example of that orchestration: The center uses one particular room to conduct interviews with child victims. The room contains a hidden video camera and a microphone, which transmit the interview to a nearby room where all the people working on behalf of the child, such as lawyers and law enforcement officers, are gathered. Having everyone present reduces the number of times a child must endure such an interview.

Schimpf recalled an interview in which a child divulged an abuser's name. In the next room, a law enforcement officer was able to communicate with the interviewer through an earpiece worn by the interviewer. During the session, the officer kept asking, "Junior or senior? Junior or senior?" Schimpf said she didn't understand the officer's concern until she realized that two people in the child's family had the same name and the officer needed to clarify which one had abused the child.

The center is kept running through the efforts of volunteers — those with and without experience, Schimpf said. The more-experienced volunteers typically have contact with children, while the less-experienced ones take on simpler tasks like cleaning or maintaining the grounds.

To help such centers, the AMA

Alliance this month kicked off an initiative called SAVE-a-Shelter. The plan encourages state and county medical alliances and societies to adopt an abuse shelter, transition home or rape crisis center, said Sandra Mitchell, president of the AMA Alliance. Adopting a shelter could involve providing technical support, donating funds, doing volunteer work or participating in drives for clothing and other essential items. Education efforts like the ISMS Alliance's billboard campaign will help people understand how violence affects their lives and what prevention efforts are available, she said.

"I think your billboard campaign is

going to win the all-time award as far as volume and numbers of billboards that are out there in this state," Mitchell told ISMS Alliance members at the conference. "What a wonderful way to tell the world that medicine really cares."

This month, the Peoria Medical Society Alliance put up 15 billboards between Peoria and Tazewell counties. To help fund the effort, the county alliance solicited sponsors from the community, and eventually 10 groups, including two local hospitals, joined. "It's been enjoyable," Rauhaus said of her work on the billboard campaign. "You get to meet people and get the sat-

isfaction of knowing that there are other people as committed to helping solve this problem as we are."

"I just hope that because of the billboards people are more aware of the problem," said Teresa Sun, president of the Marion-Clinton Medical Society Auxiliary and co-chairman of the ISMS Alliance fall conference. Marion County has a local women's shelter but also has one of the highest rates of child abuse in the state, she said. "I hope we can get more organizations to work together to help educate the community about the existence of the problem and [to find] better ways to eliminate it." ■

Exclusive **NEW** Indication

In hypercholesterolemic patients with no previous MI...

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MI**

**First
MI**

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MI**

- Well tolerated. Common adverse events are rash, fatigue, headache, and dizziness
- PRAVACHOL is contraindicated in the presence of active liver disease or unexplained persistent transaminase elevations or for patients who are pregnant or nursing
- It is recommended that liver function tests be performed before the initiation of treatment, at 6 and 12 weeks after initiation of therapy or elevation in dose, and periodically thereafter
- Discontinue pravastatin if myopathy is diagnosed or suspected

*P = 0.0001.

Reference:

1. Shepherd J, Cobbe SM, Ford I, et al. Prevention of coronary heart disease with pravastatin in men with hypercholesterolemia. *N Engl J Med.* 1995; 333:1301-1307.

In addition to diet, in hypercholesterolemic patients without clinically evident coronary heart disease, Pravachol is indicated to reduce the risk of myocardial infarction; reduce the risk of undergoing myocardial revascularization procedures; reduce the risk of cardiovascular mortality with no increase in death from non-cardiovascular causes

It is not clear to what extent the findings of the Pravastatin Primary Prevention Study can be extrapolated to a similar population of women

Please see CONTRAINDICATIONS, WARNINGS (including Skeletal Muscle), PRECAUTIONS, and ADVERSE REACTIONS in the brief summary of prescribing information adjacent to this advertisement.

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Breaking New Ground in **First MI** Prevention

IDPR DISCIPLINES

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July 1995

Ignacio Solis, Chicago – physician and surgeon license placed on indefinite probation and controlled substance license indefinitely suspended after nontherapeutically prescribing controlled substances to an undercover department investigator.

Augusto Tesoro, Montgomery, Ala. – physician and surgeon license reprimanded after being disciplined in the state of Wyoming.

Earl B. Thornton, Olympia Fields – physician and surgeon license reprimanded and fined \$2,300 after practicing on a nonrenewed license.

Alberto Torres, Chicago – physician and surgeon license reprimanded and fined \$1,400 after practicing on a nonrenewed license.

August 1995

Albert Brown, Chicago – physician and surgeon license and controlled substance license placed on probation for one year after allegedly dispensing controlled substances without controlled substances logs, dispensing more than one drug in the same container, not properly labeling said drugs, dispensing anorectic drugs for longer than approved time limits, dispensing thyroid supplements prior to receiving lab test results and inappropriately dispensing diuretics to some patients.

Robert L. McEntyre, Bloomington – physician and surgeon license placed on probation for five years and controlled substance license suspended for one year followed by probation for four years due to a substance abuse problem.

Enoch Prasad, Momence – controlled substance license placed on probation after nontherapeutically prescribing Vicodin, containing a controlled substance, to a department undercover investigator who gave a history of false injury.

Chinnaswamy P. Ramaswamy, Mount Vernon – physician and surgeon license placed on indefinite probation after allegedly committing unprofessional conduct with a female patient.

William Ricketts, Park Forest – physician and surgeon license placed on probation for one year and controlled substance license suspended for one year followed by probation for one year after prescribing a controlled substance in a nontherapeutic manner and failing to prescribe medication in good faith.

Evert M. Vander Stoep, Chicago – physician and surgeon license reprimanded and fined \$2,300 after practicing on a nonrenewed license.

September 1995

Carl Burpo, Belleville – physician and surgeon license indefinitely suspended due to alleged immoral and unprofessional conduct, controlled substance violations, failure to report adverse actions, and being named a perpetrator in an indicated report by the Department of Children and Family Services.

Kenneth Gill, Worth – physician and surgeon license and controlled substance license probationary status extended through Feb. 24, 1998, after violating a previously ordered probation.

Gene Johnson, Galesburg – controlled substance license indefinitely suspended after allegedly prescribing Lorazepam to a department employee, posing as a patient, in a nontherapeutic manner.

Dong Sun Kim, Chicago – controlled substance license placed on probation for one year after nontherapeutically prescribing anorectic medications to a department undercover investigator.

Frank Nali, Grosse Pointe Farms, Mich. – physician and surgeon license indefinitely suspended after being terminated from the Henderson County Rural Health Center due to unprofessional conduct in the care and treatment of patients, failure to report termination of privileges from Community Hospital of Monmouth, and being disciplined in the states of Iowa and Michigan.

Robert C. Watkins Jr., Chicago Heights – physician and surgeon license reprimanded after failing to report an adverse final action taken against him by the Illinois Department of Public Aid.

Edward Yavitz, Rockford – physician and surgeon license reprimanded after violating the advertising provisions of the Medical Practice Act.

PRAVACHOL®

Pravastatin Sodium Tablets

CONTRAINDICATIONS: Hypersensitivity to any component of this medication. Active liver disease or unexplained, persistent elevations in liver function tests (see **WARNINGS**). *Pregnancy and lactation.* Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus. **WARNINGS: Liver Enzymes** — HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the US over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients. It is recommended that liver function tests be performed before the initiation of treatment, at 6 and 12 weeks after initiation of therapy or elevation in dose, and periodically thereafter (e.g., semiannually). Patients who develop increased transaminase levels should be monitored with a second liver function evaluation to confirm the finding and be followed thereafter with frequent liver function tests until the abnormality(ies) return to normal. Should an increase in AST or ALT of three times the upper limit of normal or greater persist, withdrawal of pravastatin therapy is recommended. Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see **CONTRAINDICATIONS**). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see **CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism**). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect. **Skeletal Muscle** — Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see **ADVERSE REACTIONS**). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper normal limit, was rare (< 0.1%) in pravastatin clinical trials. Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy. The risk of myopathy during treatment with another HMG-CoA reductase inhibitor is increased with concurrent therapy with either erythromycin, cyclosporine, niacin, or fibrates. However, neither myopathy nor significant increases in CPK levels have been observed in three reports involving a total of 100 post-transplant patients (24 renal and 76 cardiac) treated for up to two years concurrently with pravastatin 10-40 mg and cyclosporine. Some of these patients also received other concomitant immunosuppressive therapies. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine. Further, in clinical trials involving small numbers of patients who were treated concurrently with pravastatin and niacin, there were no reports of myopathy. Also, myopathy was not reported in a trial of combination pravastatin (40 mg/day) and gemfibrozil (1200 mg/day), although 4 of 75 patients on the combination showed marked CPK elevations versus one of 73 patients receiving placebo. There was a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy (see **CONTRAINDICATIONS: Drug Interactions**). The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination. **PRECAUTIONS: General** — Pravastatin may elevate creatinine phosphokinase and transaminase levels (see **ADVERSE REACTIONS**). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin. *Homozygous Familial Hypercholesterolemia.* Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors. *Renal Insufficiency.* A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3 α -hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life (t $_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored. **Information for Patients** — Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Drug Interactions** — *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See **WARNINGS: Skeletal Muscle**. *Antipyrene:* Since concomitant administration of pravastatin had no effect on the clearance of antipyrene, interactions with other drugs metabolized via the same hepatic cytochrome isozymes are not expected. *Cholestyramine/Colestipol:* Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or 1 hour before colestipol and a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See **DOSEAGE AND ADMINISTRATION: Concomitant Therapy**). *Warfarin:* In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed. *Cimetidine:* The AUC $_{0-12}$ hr for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid. *Digoxin:* In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered. *Cyclosporine:* Some investigators have measured cyclosporine levels in patients on pravastatin, and to date, these results indicate no clinically meaningful elevations in cyclosporine levels. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine. *Gemfibrozil:* In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended. In interaction studies with aspirin, antacids (1 hour prior to PRAVACHOL), cimetidine, nicotinic acid, or probucol, no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered. *Other Drugs:* During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to diuretics, antihypertensives, digitalis, ACE inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin. **Endocrine Function** — HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced (p< 0.004) after 16 weeks of treatment with 40 mg of pravastatin. However, the percentage of patients showing a \geq 50% rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones. **CNS Toxicity** — CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class. A chemically similar drug in this class produced optic nerve degeneration (Wallierian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear (Wallierian-like) degeneration and retinal ganglion cell chromatolysis in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg/day dose. **Carcinogenesis, Mutagenesis, Impairment of Fertility** — In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose (p < 0.01). Although rats were given up to 125 times the human dose (HD) on a mg/kg body weight basis, serum drug levels were only 6 to 10 times higher than

those measured in humans given 40 mg pravastatin as measured by AUC. The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times the human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls (p < 0.05). The incidence was not dose-related and male mice were not affected. A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls. No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/- mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice. In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear. **Pregnancy: Pregnancy Category X.** — See **CONTRAINDICATIONS**. Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter 2). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (Vater association) in a baby born to a woman who took another HMG-CoA reductase inhibitor with dextroamphetamine sulfate during the first trimester of pregnancy. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus. **Nursing Mothers** — A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see **CONTRAINDICATIONS**). **Pediatric Use** — Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. **ADVERSE REACTIONS:** Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients. **Adverse Clinical Events** — All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

Body System/Event	All Events		Events Attributed to Study Drug	
	Pravastatin (N = 900) %	Placebo (N = 411) %	Pravastatin (N = 900) %	Placebo (N = 411) %
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Dermatologic Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory	7.0	6.3	0.0	0.0
Common Cold	4.0	4.1	0.1	0.0
Rhinitis	2.6	1.7	0.1	0.0
Cough				

*Statistically significantly different from placebo.

In the Pravastatin Primary Prevention Study (West of Scotland Coronary Prevention Study) (see **CLINICAL PHARMACOLOGY: Clinical Studies**) involving 6595 patients treated with PRAVACHOL (pravastatin sodium) (N = 3302) or placebo (n = 3293) the adverse event profile in the pravastatin group was comparable to that of the placebo group over the median 4.8 years of the study. The following effects have been reported with drugs in this class; not all the effects listed below have necessarily been associated with pravastatin therapy. *Skeletal:* myopathy, rhabdomyolysis, arthralgia. *Neurological:* dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial palsy), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy, anxiety, insomnia, depression. *Hypersensitivity Reactions:* An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematosus-like syndrome, polymyalgia rheumatica, dermatomyositis, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, eosinophilia, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome. *Gastrointestinal:* pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting. *Skin:* alopecia, pruritus. A variety of skin changes (e.g., nodules, discoloration, dryness of skin/mucous membranes, changes to hair/nails) have been reported. *Reproductive:* gynecomastia, loss of libido, erectile dysfunction. *Eye:* progression of cataracts (lens opacities), ophthalmoplegia. *Laboratory Abnormalities:* elevated transaminases, alkaline phosphatase, and bilirubin; thyroid function abnormalities. *Laboratory Test Abnormalities* — Increases in serum transaminase (ALT, AST) values and CPK have been observed (see **WARNINGS**). Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with HMG-CoA reductase inhibitors. **Concomitant Therapy** — Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is not associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See **WARNINGS: Skeletal Muscle** and **PRECAUTIONS: Drug Interactions**.) **OVERDOSAGE:** To date, there are two reported cases of overdose with pravastatin, both of which were asymptomatic and not associated with clinical laboratory abnormalities. If an overdose occurs, it should be treated symptomatically and supportive measures should be instituted as required.

CAUTION: Federal (USA) law prohibits dispensing without prescription.

Consult package insert before prescribing PRAVACHOL® (pravastatin sodium).

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(Continued from page 1)

mothers home with new babies within 12 to 24 hours of delivery.

Both the mental health and hospital-stay laws will take effect Jan. 1, 1998.

Although it doesn't eliminate discriminatory coverage for the treatment of mental illnesses, the mental health act nonetheless represents "a step in the right direction," according to Arden Barnett, MD, chairman of the Government Affairs Committee of the Illinois Psychiatric Society. "It's a good start toward equalizing health insurance plan cover-

age for treatment of mental illnesses and other medical conditions. While historic, this legislation still does not provide full parity between coverage for mental illnesses and other medical illnesses. Patients who need mental health services should not have to pay higher deductibles or receive less reimbursement than patients who need medical services for physical ailments."

Under the new law, insurance plans that offer mental health benefits will have to offer lifetime and annual plan payment caps for treatment of mental health that are equal to caps for other medical conditions. Lifetime limits

applied against mental health care in private health insurance plans usually range from \$10,000 to \$50,000 while limits for other medical conditions – such as cancer, heart disease or diabetes – are typically as high as \$1 million, according to the Coalition for Fairness in Mental Illness Coverage, of which the AMA is a member. Insurance providers that have no lifetime limit on physical coverage will have to drop lifetime limits on mental illness payments.

A loophole of sorts is the law's failure to require insurers or employers to offer any mental health benefits. In addition, it offers an exemption to group health

plans for which adding the mental health parity provisions would result in an increased cost of at least 1 percent. Other than provisions for equal lifetime and annual payments, the law does not keep an insurer or employer from establishing separate terms and conditions relating to the amount, duration or scope of mental health benefits. These conditions could include cost sharing, limits on the number of visits or days of coverage and requirements relating to medical necessity. The law does not cover treatments for substance abuse or chemical dependency.

The Illinois Psychiatric Society, with support from ISMS, earlier this year proposed mental health legislation in the Illinois legislature. Sponsored by Rep. Carolyn Krause (R-Mt. Prospect), the proposed law went further than the federal legislation. The bill would have required insurers who provided coverage for hospital or medical expenses under a group or individual accident and health insurance plan to cover the treatment of serious mental illness under the same terms and conditions as treatment for other illnesses and diseases. Durational limits, amount limits, deductibles and co-insurance requirements would have been the same for serious mental illness as for other sicknesses. The measure did not emerge from the House Health Committee.

"We'll certainly take another look at the mental health parity issue to see what more could be done when the new Illinois General Assembly convenes in 1997," Krause said.

COMMENTING ON THE MINIMUM two-day hospital maternity stay the president signed, M. Leroy Sprang, MD, chairman of the ISMS Board of Trustees, said, "This is truly significant legislation. Giving birth is a physically demanding situation. Mothers need time to heal physically, to feel comfortable with a new baby and make sure the infant is being nourished adequately. There's no data that says it's safe to send a mother and baby home within 24 hours. Jaundice and other infections may not show up within that time. The federal bill is significant because it extends coverage to all mothers and babies in the U.S."

Gov. Jim Edgar signed a similar Illinois law last July, which went into effect Sept. 17. That law also requires insurers to pay for at least 48 hours of in-patient care for mothers and newborns following a vaginal delivery and 96 hours following a cesarean section.

In drafting the federal legislation, Congress noted that determining when a mother and her newborn are discharged is the domain of the attending physician in consultation with the mother. The act also requires the U.S. Department of Health and Human Services to establish an advisory panel of public- and private-sector representatives, including health care providers, within 90 days to study factors and draft a report regarding the continuum of care for new moms and babies. The panel's study will include how "postnatal care has changed over time and the manner in which that care has adapted or related to changes in the length of hospital stays." The initial report is due within 18 months.

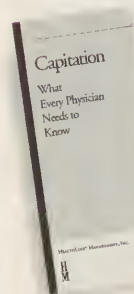
Both the mental health and hospital-stay health care provisions were included in a final version of an \$87 billion fiscal-year 1997 spending bill for the Veterans Affairs, Housing and Urban Development and Independent Agencies departments. ■

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IDPA files

(Continued from page 1)

name on the form if the physician has contracted with IDPA to be a primary gatekeeper. IDPA will also distribute stickers to primary care doctors, who can then give them to their patients for attachment onto the form.

Patients have 60 days to choose an option, at which time IDPA will send a duplicate form giving them another 30 days to make a choice. If IDPA receives no response to the second notice, it will make at least one attempt to contact those patients directly, Hovanec said. Patients who have not chosen an option at that point will be defaulted into a managed care entity, said Hovanec. But defaulted patients can disenroll from that managed care entity and select another provider within 60 days, he said.

The time line for implementing MediPlan Plus still depends on HCFA's approval of the protocols, Hovanec said. The earliest the state plans to let Medicaid recipients begin choosing among their health care options is July 1997. To contract with MediPlan Plus, managed care entities must go through a bidding process, which the state plans to start in spring 1997. Physicians might be able to sign up as gatekeepers as early as June. HCFA must still approve paperwork for the processes of enrolling patients and managed care entities in the program.

The rules also address marketing by managed care entities and physicians. The door-to-door marketing now practiced by some managed care plans will be prohibited. If plans or physicians use marketing representatives, those reps must be registered with IDPA and licensed in accordance with their contract and applicable rules and regulations of the Illinois Department of Insurance.

In addition, HCFA and IDPA must

approve marketing materials. The rules allow physicians to provide such materials to Medicaid patients but only in common areas like reception rooms, not in treatment rooms. However, that restriction doesn't apply to physicians when they talk to their patients about continuing that physician-patient relationship.

For emergency care, Hovanec said the rules use the "prudent layperson" definition — "the provision of those health care services for a medical condition of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent or unscheduled med-

ical care is required."

According to the rules, special handling will apply to certain populations — for example, children with chronic conditions and individuals with severe mental health conditions, Hovanec said. The state will also commission ongoing quality assurance reviews for participating managed care entities.

"Overall, the rules seem rather reasonable," said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. "They address some of the issues that have been a concern for us." ISMS had input into the rules and will continue monitoring each step, he added. ■

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Physicians can
help put a lid
on teen drinking

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • NOVEMBER 8 1996

More hospitals
opt for
affiliations,
survey says

PAGE 2

ISMS co-sponsors conference on violence prevention

INVOLVEMENT: A program to obliterate gang tattoos is only part of physicians' efforts.

BY JANE ZENTMYER

[CHICAGO] Through Operation Fresh Start, physicians have removed tattoos from more than 900 young people to date, and 1,800 others are waiting to have their tattoos removed, according to John May, MD, who helped launch the program. Begun last January by the Sinai Family Health Centers, the program has been used by gang members who want to leave their gangs. It operates out of Chicago's Madison Family Health Center.

A 1995 recipient of the Illinois State Medical Society Physician Public Service Award, Dr. May talked about the tattoo removal program and physicians' efforts to prevent violence at a session of the "Creating Peaceable Communities" conference organized by the Illinois Council for the Prevention of Violence and sponsored by ISMS and more than 30 other groups. Held on Oct. 4 and 5 in Chicago, the conference examined many forms of violence – including acts committed against children, women and the elderly – and methods that can be used to stop the violence.

Dr. May listed the benefits of Operation Fresh Start: "The most important thing it probably does is improve self-esteem." He added that young people often get tattoos when they're young and think it's cool. Eventually, though, the tattoos become a reminder of such problems as gang involvement, he explained. "Another important thing that [the program] does is improve their employability. Third, and perhaps most importantly, I believe it will reduce injuries."

A tattoo is one of five risk factors physicians should identify when determining whether a patient is likely to become a vic-

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Advisory Board
determines
driver fitness



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Case raises issue of disclosure of HIV test results

CONFIDENTIALITY: Illinois law establishes rules and exemptions for testing for HIV and releasing patient records. BY JANE ZENTMYER

[CHICAGO] In a recent decision, a Mississippi circuit court upheld a lower court's dismissal of a woman's lawsuit against an insurance company that failed to tell her late husband he was HIV positive, according to the September issue of the National Health Lawyer News Report. In 1988, an insurance company required the man, Frank Doremus, to take a routine blood test before increasing his life insurance. After testing him, the insurer turned Doremus down citing "confidential medical information" but refused to provide more explanation. Eighteen months later, Doremus learned he was infected after his own physician ran blood tests. The insurer said it was not required to disclose test results under state law, although the compa-

ny subsequently began such disclosure. The plaintiff is lobbying to make disclosure mandatory under federal law.

This and other cases, as well as related media reports, have emphasized the confusion over disclosure of HIV test results. In Illinois, the AIDS Confidentiality Act, passed in the late 1980s, sets guidelines for physicians and others to follow when testing for HIV and releasing the results.

"The AIDS Confidentiality Act specifically says that no person may disclose or 'be compelled' – that means ordered to disclose – the identity of the person who is tested or the results of the test," said ISMS General Counsel Saul Morse. "It's not just the result of the test [that is protected]; it's the fact that a patient was tested in the first place as well."

A standard legal release form for medical records doesn't satisfy the law's requirements for a "legally effective release," Morse said. A proper release must specifically refer to HIV/AIDS records and must be executed by the test subject or the subject's legal representative.

The law does, however, outline exceptions that allow disclosure of information without an effective release form, Morse said. Information about the results of an HIV test may be provided to agents or employees of a health facility who have a "need to know" about them. Someone with a need to know, Morse said, is "generally defined as anyone providing direct care or handling blood or bodily fluids."

Based on their best medical

(Continued on page 7)

AMA to implement first step in accreditation program in January

CREDENTIALING: AMAP will incorporate five areas of physician evaluation. BY DEBORAH PREISER

[CHICAGO] As January 1997 approaches, so does implementation of the first phase of the AMA's American Medical Accreditation Program – a nationwide, standardized accreditation program for physicians. The first phase includes three of the five areas of evaluation – credentials, personal qualifications and environment of care. The other two areas, clinical performance and patient care results, will be implemented over the next two to three years, according to the AMA.

The program is intended to replace the duplicative credentialing processes and office site visits of different managed care entities. Eventually it should provide meaningful feedback that physicians can use to

improve the quality of care they provide, according to the AMA.

States participating in the initial phase are Massachusetts, New York, Minnesota, Texas, Alabama, Utah and Oregon, according to William Jessee, MD, AMA vice president for quality and managed care and head of the AMA team that designed and will implement AMAP. Physicians in Illinois and other states will be able to seek AMA-sponsored accreditation during the next two years, he added.

"AMAP will be offered first in states where the state medical societies contacted us," Dr. Jessee said. "Not surprisingly, all the states but Alabama have a high penetration of managed health plans. In some, the state

(Continued on page 15)

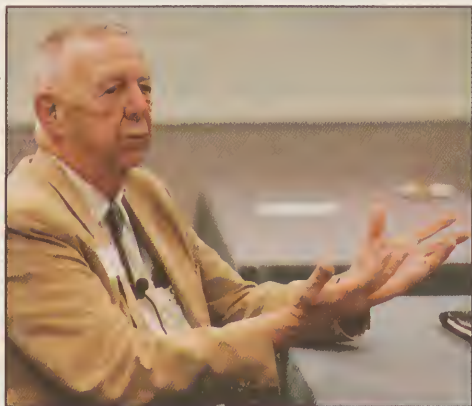


Vince Pierri

ISMS PRESIDENT Sandra Olson, MD (left), and Lake County Medical Society President Clair Callan, MD, chat during a break in a program for women physicians conducted by the Lake County Medical Society. Dr. Olson spoke at the Oct. 8 meeting in Lake Forest as part of her President's Tour.

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Robert Heerens, MD, of Rockford, makes a point during an ISMS speaker training seminar held Oct. 10 at the Marriott Suites in Downers Grove. Physician participants earned CME credit and developed skills to help them speak on health-related issues through the volunteer ISMS Speakers Bureau.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by β -adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however, no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patients sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral α -adrenergic blockade. These include anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence:^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage is to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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More hospitals opt for affiliations, survey says

[CHICAGO] The number of hospitals pursuing managed care affiliations is increasing, outpacing the growth in mergers and acquisitions, according to a recent national survey of 224 hospitals conducted by TriBrook/AM&G, a Chicago-based health care management consulting firm. Nine of the hospitals surveyed were located in Illinois.

Although only 18 percent of hospitals said they are currently affiliated with a hospital network, 48 percent expect to be affiliated by the year 2000. Fifty-two percent of the respondents are currently freestanding hospitals, but only 12 percent expect to remain freestanding by 2000.

Twenty-five percent of the hospitals surveyed had been involved in a merger or acquisition, but only 17 percent of respondents indicated they are currently pursuing such opportunities. Hospitals cited loss of autonomy and lack of trust among the hospitals involved as drawbacks to merger and acquisition but still rated this type of collaboration as more successful than affiliation. "The survey clearly shows that while there may be initial suspicion of the merger or acquisition process, hospitals that have taken the plunge find the benefits are well worth it," said Rufus Harris, who helped develop the survey. ■

U of C Hospitals unveils advanced medicine center

[CHICAGO] On Sept. 9, University of Chicago Hospitals opened the doors to the new \$150 million outpatient facility called the Duchossois Center for Advanced Medicine, according to hospital officials.

"The old clinic space, much of it erected in the late 1920s, then remodeled and extended bit by bit for 70 years, had become a bewildering maze for patients," said Glenn Steele Jr., MD, PhD, vice president of medical affairs at U of C Hospitals. "Now, even for patients who need to see several different specialists or have a battery of diagnostic tests, scheduling and way-finding will be quite simple."

The center is organized in patient-oriented units rather than by academic

department. All cardiopulmonary services, for example, are concentrated on one floor, with exam rooms on one side, and diagnostic and treatment equipment on the other. Included are clinics and outpatient diagnostic services for heart disease, cardiac and thoracic surgery, endocrinology and lung disorders.

The center has 209 oversized exam rooms to accommodate family members and physicians in training. It has 62 rooms for outpatient procedures, including five operating rooms for ambulatory surgery.

The Richard Duchossois family made a \$21 million donation to the University of Chicago to build the center, which is the largest dollar amount the university has ever received from one family. ■

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Medical Advisory Board determines driver fitness

COMPLIANCE: Drivers with certain mental and physical conditions must submit a medical report. BY JANE ZENTMYER

[SPRINGFIELD] Most Illinoisans know that the secretary of state's office reviews medical reports related to driver's license renewals and determines whether the licenses should be renewed. What they may not know is the scope of that undertaking. Medical and vision reports – which involve two separate forms – come in by the thousands every year. The state received 43,879 such reports in 1995 and has already received 38,307 reports from January through September 1996, according to the secretary of state's office.

Driver's license applicants must, of course, complete forms that ask questions about their medical history. If certain conditions such as epilepsy are marked, applicants must pick up a medical report form at the secretary of state's office and have it completed and signed by a physician. The medical reports can be triggered by various sources, according to Mark Novak, assistant general counsel for the secretary of state.

Drivers' ability to drive may be questioned by law enforcement officials, physicians, secretary of state employees, judges or employees of the U.S. Department of Transportation. If any of these individuals submits to the secretary of state written comments or a recommendation based on firsthand knowledge or an official investigation, drivers must submit a medical report, Novak said.

In addition, computer databases that track drivers who move from state to state might also indicate which drivers should be filing medical reports. According to a state law that became effective last July, people who become aware of a medical condition that causes them to lose consciousness must notify the secretary of state's office within 10 days of learning of the condition, Novak said.

Illinois does not require physicians to automatically notify the secretary of state's office about patients' medical conditions that could impair their driving ability, Novak said. However, if physicians do decide to contact the state or their patients ask them to complete medical reports, state law grants immunity from liability to those doctors, he added.

Most patients who are subjects of medical reports are deemed by their physicians to be able to drive. But the law outlines those cases – for example, complex or ambiguous ones – that should be referred to the Medical Advisory Board. "We have about 15 mem-

bers, and they represent the specialties that are most often concerned, such as neurology, psychiatry, ophthalmology, orthopedics and internal medicine," said Frank Norbury, MD, a retired Jacksonville internist who has been the board's chairman for at least 15 years.

Cases may be referred to the board if they involve conflicting medical opinions, a contested denial of a license or ambiguous information, Dr. Norbury said. In 1995, the Medical Advisory Board reviewed 718 cases, and, so far this year, the board has examined 619 cases, according to the secretary of state's office.

Each case requiring board review is evaluated by a board member representing the specialty most closely related to the medical condition in question. That board member then makes an informal recommendation, which is reviewed by the board chairman, who issues a formal recommendation. The informal and for-

mal recommendations usually concur, Dr. Norbury said.

The medical criteria reviewed by the board include drivers' ability to sit stably in an erect posture, to sustain consciousness when behind the wheel and to recall their place of destination and the significance of road signs, according to the rules for implementing the law. Occasionally, the board may request an additional physical exam before making a determination, Dr. Norbury said. The board can deny a license based on a medical condition, grant the license in its entirety or grant the license with restrictions.

(Continued on page 14)



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REPORT for Illinois Physicians

MEDICARE CARE PLAN OVERSIGHT - BILLING GUIDELINES CHANGE

Health Care Financing Administration (HCFA) defines physician, for care plan oversight (CPO) services, as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.). CPO is comprised of physician supervision of patients under the care of home health agencies or hospices who require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Implicit in the concept of care plan oversight is the expectation that the physician has coordinated an aspect of the patient's care with the home health agency or hospice during the month for which care plan oversight services were billed.

HCFA extended Medicare coverage to CPO effective January 1, 1995, and allows separate payment for HCPCS code 99375 for CPO services exceeding 30 minutes per month only for patients who are receiving Medicare covered home health or hospice benefits. Since Medicare does not pay for more than 60 minutes of CPO in a calendar month, payment for 99376 (CPO over 60 minutes) is considered bundled into 99375. Medicare does not pay for care plan oversight services for nursing facility or skilled nursing facility patients.

Review of calendar year 1995 CPO claims data indicates that many claims submitted may fail to meet the Medicare coverage criteria for payment. To ensure adherence to the policy for CPO, HCFA is changing the process for billing CPO.

Effective *January 1, 1997*, three new HCPCS codes for CPO will differentiate among patients receiving home health, hospice and nursing facility services and will replace 99375. Effective January 1, 1997, physicians must use HCPCS code G0064 to bill CPO for beneficiaries receiving Medicare covered home health services and HCPCS G0065 to bill CPO for beneficiaries receiving Medicare covered hospice services. HCPCS code G0066 effective January 1, 1997, designates CPO services to beneficiaries receiving nursing facility or skilled nursing facility services. G0066 will have a bundled status, and no separate payment will be allowed since payment for care planning for nursing home patients is bundled into the physician's payment for evaluation and management services.

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EDITORIAL

Too much growth

Why stay we on the earth except to grow?' wrote Robert Browning. We Americans have been growing a little too much lately – in girth, that is. A study released Oct. 15 by the National Center for Health Statistics showed that overweight people in the United States for the first time outnumber normal-weight Americans, according to the New York Times. Researchers figured the body mass index on 30,000 subjects and found that 59 percent of the men and 49 percent of the women had BMIs over 25, a jump from 10 years ago when 51 percent of men and 41 percent of women were that heavy.

In the Times, a physician summed up the cause: "It's just eating too much. Physical activity hasn't increased enough to keep up with it."

Another study, released in early September by the New England Journal of Medicine, showed that we've experienced some ups and downs in our dietary habits. The study compared trends in different economic groups. In 1965, the lowest percentage of respondents eating a healthful diet were wealthier whites, and poorer blacks scored highest, which researchers attributed to the former group's ability to afford food high in saturated fat. By 1991, the wealthier whites had made the biggest strides, but poorer whites and blacks had made less progress.

Commenting on the study, a nutritional specialist from the University of

Illinois at Chicago said that less than a quarter of any of the groups met even four of the eight recommendations for dietary improvement developed by the National Academy of Sciences, according to the Chicago Tribune. Another nutritionist said we Americans spend half our food dollars and consume one-third of our calories away from home, eating food that isn't labeled for nutrition and is served in "out of control" portions.

"The hot new diet pill" is the cover story for the Sept. 23 issue of Time, and that pill, of course, is Redux. The story conjectures that overweight Americans are primed to beg their physicians for it, despite its potentially serious side effects and its intended usage for morbid obesity: "The United States is one of the fattest countries on earth and at the same time the most obsessed with slimness. We will try just about anything – short of giving up our overeating, couch potato habits."

Time quoted a cardiologist at Rush-Presbyterian-St. Luke's Medical Center who co-wrote a Redux study in the New England Journal of Medicine: "In Europe, the majority of people who have taken Redux were looking to lose 10 to 20 pounds. You can just imagine how popular this medication is going to be here."

Let's hope he's wrong and our patients who are overweight but not obese will lose weight sensibly – by practicing healthy eating habits and exercising.

PRESIDENT'S LETTER

Death and dying

Sandra F. Olson, MD



A terminal diagnosis does not mean we should end our involvement with and care for those who count on us.

The recent news articles about Cardinal Bernardin's decision to forgo further palliative chemotherapy treatment for his pancreatic cancer have focused attention on the humanistic and personal issues of patients who have terminal illnesses and face imminent death. It raises important questions for us as doctors and carries a significant message not only for the medical profession but for all of us mortals.

We all know that no one gets out of this world alive. But we physicians usually view our role in medical care as that of warriors using all the weapons at our disposal to fight the diseases in our patients and stave off death as long as possible. Those are basic tenets of our profession. But Cardinal Bernardin's dignified acceptance of the finality of his case reminds us of our fallibilities as healers. While potentially depressing, this can prove to be a personal inspiration for us as we ponder the lofty courage with which so many patients receive and cope with the diagnosis of an inevitably fatal condition. That courage is humbling and reminds us of our own mortality and limitations and often evokes a philosophical self-examination.

Dr. Elisabeth Kubler-Ross was a writer and pioneer who studied and aggressively publicized the psychological aspects of dying – a subject basically ignored by the medical profession until then and hardly researched. She described the steps a patient goes through both emotionally and spiritually in this process. I had advanced personal knowledge of her book, as some of it was typed by our secretary when I was studying neuropathology under Elisabeth's husband, Dr. Emmanuel Ross. Later, Elisabeth extended her efforts to crusading for the right of patients with terminal illnesses to die in a comforting and compassionate environment with adequate pain relief and their right to decline futile attempts to prolong life. Her emphasis was on comfort and love and spiritual, physical and emo-

tional support for these patients – in short, what hospice care is all about today and what many patients prefer to the high-tech, often impersonal hospital setting.

As physicians, we are increasingly coming to an understanding of the dying process and dying patients in contrast to our old avoidance behavior toward these patients. When I was a resident in the '60s, a diagnosis of an incurable disease state in a patient meant one less patient we had to deal with, one more patient off the daily roster. Our role in that patient's care seemed to end immediately. We thought our responsibility was over since there was nothing more we could do medically.

Humanism was certainly lacking in this approach, sad to say. Now, thank God, that attitude has changed. A terminal diagnosis does not mean patients should stop making plans for the future or that we should end our involvement with and care for those who count on us. The Chicago Tribune quoted Cardinal Bernardin on Oct. 18th as saying, "I'm here today – I've got plans for tomorrow and the weekend. It's not over yet." Often, accepting the natural process eventually gives patients a sense of peace. But we still must strive to keep improving our attitudes. We must remain faithful to the trust our patients place in us. Patients continue to voice concerns about being abandoned and left to die in a painful, undignified state. We must constantly reassure them, address their fears openly and crusade actively for the use of advance directives, aggressive pain relief and programs like hospice.

Cardinal Bernardin's outstanding example of dignity, strength, religious conviction and good humor will serve to shine a light on this element of medical care. I hope we continue to follow this beacon and let it help light our way as we continuously strive to truly treat our patients from cradle to grave.

GUEST EDITORIAL

Lock up Juan Valdez!

By Eric Julber

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Now that Clinton, Kessler & Co. have vanquished the Tobacco Monster, the question arises: What will we next be protected from? I predict the next Demon Drug to be exorcised from the Great Society will be caffeine, and specifically its prime delivery system, coffee. And unlike the case against tobacco – which took decades of studies, hearings, lawsuits, experts and millions of dollars and hours to prove – the case against coffee has already been made.

The august American Psychiatric Association, based in Washington, D.C. (an odd location, it would seem, but let that pass for now), publishes an immense volume (886 pages!) found in every member's office. Formally called the Diagnostic and Statistical Manual of Mental Disorders, the current fourth edition has the catchy nickname DSM-IV.

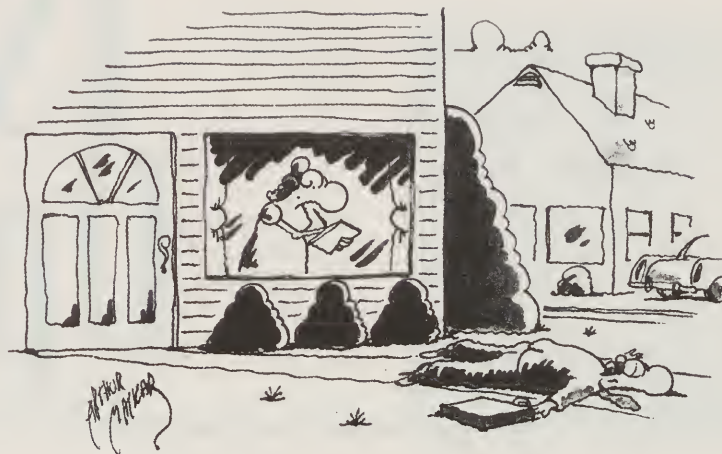
On page 212, DSM-IV lists a rich menu of "Caffeine-Induced Disorders." Disorder #305.90 (every mental disorder has its own serial number, rather like those found in an auto-parts catalog) is

"Caffeine Intoxication." DSM-IV sets out in grim detail the "Diagnostic Criteria for #305.90 Caffeine Intoxication":

A. Recent consumption of caffeine, usually in excess of 250 mg (e.g., more than 2-3 cups of brewed coffee). [DSM-IV is referring to very small cups. Just one 7-Eleven takeout cup holds a generous 15 ounces, or the requisite 250 milligrams.]

B. Five or more of the following signs, developing during, or shortly after, caffeine use: (1) restlessness, (2) nervousness, (3) excitement, (4) insomnia, (5) flushed face, (6) diuresis, (7) gastrointestinal disturbance, (8) muscle twitching, (9) rambling flow of thought and speech, (10) tachycardia or cardiac arrhythmia, (11) periods of inexhaustibility, (12) psychomotor agitation.

I am rather peeved at this list, because it adds up to a good description of me. I thought this was how hard-working, ambitious people were supposed to be: "restless," "excited," "inexhaustible." Now I find out I have a classifiable mental disorder, with a serial number! (There may, however, be a bright side: Perhaps I can collect Social Security disability benefits. At least a handicapped parking sticker?)



"Monday, 8:30 a.m.: My first attempt to switch Evan to decaf has been a failure."

But DSM-IV doesn't stop there. It gets worse. Much worse. Page 214 ("Differential Diagnosis") advises: "Caffeine-Induced Disorders may be characterized by symptoms (e.g., Panic Attacks) that resemble primary mental disorders (e.g., Panic Disorder vs. Caffeine-Induced Anxiety Disorder, With Panic Attacks, With Onset During Intoxication)."

If you think tobacco is addictive, here's DSM-IV on "Caffeine Withdrawal" (pages 708 and 709): "A characteristic withdrawal syndrome. Drowsiness, fatigue and mood changes from coffee withdrawal can mimic amphetamine or cocaine withdrawal." Symptoms include "headache," "marked anxiety or depression," "nausea or vomiting" and "wors-

ened cognitive performance (especially on vigilance tasks)."

And whereas tobacco's ill effects are delayed for decades, the systems of caffeine intoxication are immediate: "during or shortly after caffeine use," DSM-IV says. Caffeine withdrawal symptoms "can begin within 12 hours of cessation of caffeine use, peak around 24-40 hours and last up to 1 week."

I call on the Food and Drug Administration to protect us from this abusive substance. Ban coffee in offices and public places! Stamp out secondhand coffee fumes! Java and mocha by prescription only! And – most important – no espresso machines within 1,000 feet of any school!



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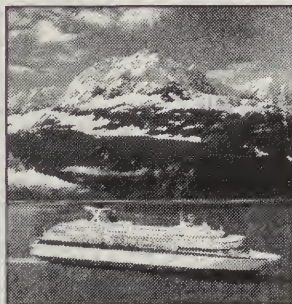
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ISMIE Update

Documentation, follow-up are essential in risk management

SIMPLICITY: To work, procedures have to be specific but not complicated, seminar says. BY DEBORAH PREISER

[CHICAGO] Next to providing high-quality care, documenting that care correctly is one of the most important things physicians and their support staff can do, according to presenters of the seminar "Risk Management: An Essential Office Practice" held Sept. 25 in Chicago. More than 100 office managers, physicians and nurses attended the program, where they were told that good documentation is written objectively, not subjectively.

Be specific, said an ISMIE professional claims analyst, citing an example of objective and subjective documentation. "Write 'patient reported discontinuation of penicillin on day seven of 10.' A notation such as 'patient is not cooperating with recommended treatment' is not supported by facts and is open to interpretation — often the wrong interpretation — by others. Subjective notes in a patient's file are not helpful if you ever need to recall the specific steps taken in treating a patient.

"Altering or embellishing records once a dissatisfied patient has filed a lawsuit is a big mistake," she continued. "By then, the opposing attorney already has a copy of the original records. It becomes extremely difficult — if not impossible — to defend a case when it

becomes obvious that someone has altered the original records."

If a mistake in the records is noticed, draw a single line through the entry so that it can still be read, add the word "error," make the correction and initial and date it, the analyst suggested. "If you need more space to add information, use an addendum to add the correct information and date it. Never obliterate any entry by crossing out, cutting out or using White-out."

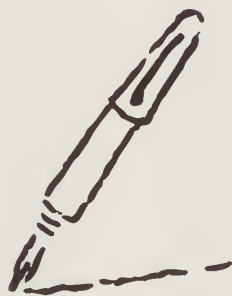
It's also important to keep accurate records of all clinically relevant telephone calls, even those physicians make or receive away from the office. "When a patient calls for advice or a prescription refill, or when a patient calls to report a complication, the advice or instructions the doctor gives should be noted on the chart along with the date and time of the call," the analyst said. "Missed appointments as well as any communication with other health care providers such as referring or consulting physicians should also be noted."

"The need for meticulous documentation and other risk management practices has become much more acute since the 1970s when the number of patients filing malpractice law-

suits started to climb dramatically," said an ISMIE risk management specialist. "The purpose of adopting good practices is not just to prevent litigation but to eliminate the conditions that encourage it."

Good physician-patient communication can create a tremendous amount of good will, she said. Patients who decide to sue doctors often cite these problems with physicians or office staff: lack of concern and friendliness, failure to fully explain a problem or procedure, failure to discuss a bad result, decision-making without patient consultation, lack of availability in times of need, and failure to follow up on patient phone calls, missed appointments, referrals, test results, prescription refills and discharge instructions.

Following up with test and X-ray results is not easy in a demanding practice, the risk management specialist said. Follow-up systems that can be simple but effective include a log, a



ISMIE expands brokerage option by contracting with Peoria broker

CHANGE: McLaughlin & Sons Inc. joins roster.
BY JANE ZENTMYER

[CHICAGO] In September, ISMIE added Peoria-based McLaughlin & Sons Inc. to the roster of brokerages authorized to represent ISMIE and sell its products, according to Harold Jensen, MD, chairman of the ISMIE Board of Governors.

Working with brokerage firms enables ISMIE to expand the range of options offered to policyholders, Dr. Jensen said. The McLaughlin contract will allow ISMIE to expand the broker option to another geographic area of the state.

The Peoria broker was founded in 1936 by E. F. C. McLaughlin, whose son Dennis McLaughlin is the current president. The founder's grandchildren are the agency's three vice presidents — Patrick McLaughlin, Martin McLaughlin and Mary Ellen DeBord, each of whom has more than 10 years of experience in the insurance field. Since its origin, the company has insured large medical accounts and maintains

long-term relationships with its clients and carriers, according to DeBord.

"My husband is a physician, which I think makes us more sensitive to the claims process that a physician has to endure," DeBord said. "Our responsibility is to represent physicians, and we will only do that with carriers who respond to their needs." For many years, physicians have relied on ISMIE to offer a quality product that meets their needs, she added.

The agency has already earned a reputation among physicians, DeBord said, citing the Peoria Medical Society's endorsement of the firm as a carrier of long-term disability insurance for physicians.

The other brokers approved by ISMIE are Aon, Classic Insurance Services Ltd., Diederich Insurance, Medical Arts Insurance Affiliates Ltd., Medical Group Insurance Services and Kamensky Group.

monthly calendar, a tickler system of index cards or a computer software program. The type of follow-up system is not as important as its routine use.

After the presentation, attendees asked specific questions

ranging from concerns about patient confidentiality when managed care companies ask to review office charts to procedures for sending collection letters. Office staff members also asked about giving patients their medical records (which by law belong to the physician or the practice, not the patient), following up with noncompliant patients and faxing prescriptions to pharmacies.

More than 1,000 Illinois physicians and their office staff members have attended the "Risk Management: An Essential Office Practice" seminars presented during 1996 at 14 locations throughout the state. The seminars are designed to help doctors and their staff provide better-quality medical care, prevent patient injury and reduce their chances of being targets of litigation. ■

A documentation success story

When an irate patient called his HMO to complain about a cardiologist's alleged lack of response to his medical needs, the HMO called the physician's office to find out why the doctor failed to schedule an appointment with the patient.

Fortunately, office manager Kathleen Tanner — who attended the ISMIE seminar "Risk Management: An Essential Office Practice" in Chicago recently — documents every call. She said that by checking her notes, she was able to tell the inquirer what date the man called and what their conversation had been. Essentially, Tanner had explained to the patient that the cardiologist was out of town and that the office was closed. She had then referred the caller to two other cardiologists in the area. She also checked her roster of patients. "There was no record that this man had ever been our patient," Tanner recalled. She heard nothing further

from the caller until he phoned several weeks later, became "quite abusive" and then reported his dissatisfaction to his HMO, she said. The HMO assured Tanner she had followed proper procedure to the letter.

It might seem that someone like Tanner wouldn't need a risk management seminar, but she said, "Even though I've been an office manager for 10 years, seminars like this alert me to the constant need for documentation. As medicine keeps changing, especially with managed care, new issues arise that need to be addressed."

Many attendees said they planned to implement changes as a result of the seminar by reviewing procedures for releasing records, documenting all communications with patients, creating brochures to explain office policies and developing better systems for logging test results.

— Deborah Preiser

Case raises issue

(Continued from page 1)

judgment, physicians may also release HIV test information to certain people determined to have been exposed to HIV through accidental direct contact with the skin, mucous membrane, blood or bodily fluids of an individual who may have HIV, Morse said. Those people subject to such exposure are health facility employees, law enforcement officers, emergency medical personnel and firefighters.

When a patient tests HIV positive, physicians may notify the spouse if they have first unsuccessfully tried to convince the patient to tell the spouse. Physicians may also inform a spouse if, after a reasonable time frame, they have reason to believe that the patient failed to notify a spouse after agreeing to do so. If the patient is a minor, physicians may inform a parent or legal guardian under the same circumstances as allowed for spouses. However, "the physician has no legal duty or obligation to notify the spouse," Morse added. The same is true for a minor's parents or legal guardian.

Other exceptions allow physicians to provide test results to the patient or the patient's legally authorized representative; any individual designated in a legally effective release; a health facility or provider who procures, processes, distributes or uses a human body part from a deceased person or semen provided before the effective date of the AIDS Confidentiality Act to use for artificial insemination; health facility staff committees for program monitoring, evaluation or service reviews that include peer review activities; and any temporary caretaker of a child taken into protective custody by the Department of Children and Family Services.

The Illinois Department of Public Health, when authorized by law, may receive the confidential HIV/AIDS information but may not further disclose that data to any court, tribunal, board or agency, Morse said. In certain circumstances, however, health department officials may release the names of HIV-positive children to school principals.

PHYSICIANS SHOULD TAKE STEPS to protect patients' HIV or AIDS records. Segregating the records from other information about the patient will help ensure that the HIV or AIDS records aren't accidentally released in response to a general request for records, particularly since the general release form doesn't cover HIV/AIDS records, Morse said. For example, records may be separated from other information on a patient's chart or by placing a separate envelope containing the records along with the chart. If physicians use envelopes, though, they should stuff envelopes with the same amount of paper as the HIV/AIDS records contain and attach those envelopes to all other patients' charts. That way, no one can distinguish which envelopes contain the HIV/AIDS records. "Whatever your approach, you have to do it for every single chart," Morse said.

The guideline for obtaining consent to release patient records, however, is different from receiving consent to test the patient for HIV. Physicians should get written informed consent from patients whenever possible before testing for HIV, despite some broad exemptions in the AIDS Confidentiality Act, Morse said. IDPH has a sample form that physicians

may adapt and use to obtain patients' written informed consent for testing. To request it, physicians may write to IDPH, AIDS Activity Section, 525 W. Jefferson St., Springfield, IL 62761.

One exemption allows doctors to test patients when such testing is medically indicated, Morse said. "When physicians have authority or consent from their patients to provide care or treatment and they believe that care or treatment is medically necessary, they can order a test for HIV without specific written informed consent from patients," he noted.

In addition, written informed consent for testing is not needed when informa-

tion will be used for research and the identity of the subject is not released, the researcher cannot obtain the test subject's identity and the subject is not informed of the results. Other exceptions include testing performed on a human body part to be used according to the Uniform Anatomical Gift Act or semen provided for artificial insemination and testing on law enforcement officers, emergency medical personnel, firefighters, and health care providers and their employees when they are involved in an accidental direct contact with skin, mucous membrane, blood or bodily fluids of an individual who may have HIV, Morse said. ■

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* $P = 0.0001$

Reference:

I. Shepherd J, Cobbe SM, Ford I, et al. Prevention of coronary heart disease with pravastatin in men with hypercholesterolemia. *N Engl J Med.* 1995; 333:1301-1307.

In addition to diet, in hypercholesterolemic patients without clinically evident coronary heart disease, Pravachol is indicated to reduce the risk of myocardial infarction; reduce the risk of undergoing myocardial revascularization procedures; reduce the risk of cardiovascular mortality with no increase in death from non-cardiovascular causes.

It is not clear to what extent the findings of the Pravastatin Primary Prevention Study can be extrapolated to a similar population of women.

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IDPR DISCIPLINES

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October 1995

Scott Carlson, Washington – physician and surgeon license and controlled substance license placed on probation until Oct. 6, 1998, for allegedly improperly obtaining refill prescriptions of Tylenol No. 3, Diazepam and Tussionex without

the express consent of his attending physician.

Juliet Dumlao, Oak Park – physician and surgeon license revoked due to criminal conviction of multiple felonies involving controlled substances.

Kenneth Jones, Chicago – physician and surgeon license revoked after abandoning a patient, whom he had been treating at Herrin Hospital, where he had admitted the patient.

Jaspaul Parmar, Wilmette – physician and surgeon license reprimanded after failing to report his suspension from the Howe Developmental Center to the department.

Randolph Roller, Springfield – physician and surgeon license placed on probation for five years for failure to report his dismissal from the staff of Memorial Medical Center for excessive use of alcohol.

Alan Skirball, Boca Raton, Fla. – physi-

cian and surgeon license placed in refuse-to-renew status due to gross negligence in the treatment and care of a patient.

November 1995

Alfonso Vera DeLeon, Macomb – physician and surgeon license revoked due to gross negligence in the treatment of two patients.

Peter B. Dragisic, Chicago – physician and surgeon license issued and placed on indefinite probation for alleged history of substance misuse.

Charles F. Eddingfield, Carthage – physician and surgeon license placed on probation for a minimum of three years, and controlled substance license suspended for three years for allegedly non-therapeutically prescribing controlled substances for four patients, failing to keep a controlled substance dispensing log for Lorcet samples that he dispensed to patients and failing to use the legally required triplicate prescription forms for designated prescriptions.

Robert E. Galloway, Chicago – physician and surgeon license placed on indefinite probation after being disciplined in the state of Texas.

Robert Gloss, Chicago – physician and surgeon license indefinitely suspended for alleged gross negligence in the treatment of a patient and surrendering medical license in Minnesota.

Martha Hernandez, Chicago – physician and surgeon license placed on probation after defaulting on an Illinois Student Assistance Loan.

Lyle F. Parks, River Grove – controlled substance license placed on probation until Jan. 1, 1999, for failure to maintain a current controlled substance log.

December 1995

Hiroshi Eguro, Joliet – physician and surgeon license reprimanded and fined \$2,000 for alleged gross negligence in the diagnosis of a patient by failing to make the clinical diagnosis of ruptured Achilles tendon.

Neil R. Hirsch, Moline – physician and surgeon license placed on probation for two years after entering into a plea agreement in Arizona that resulted in a felony conviction and being terminated from the Illinois Department of Public Aid Medical Assistance Program based on conviction.

Phillip E. Lawless, Peoria – controlled substance license placed on probation for one year after allegedly nontherapeutically prescribing controlled substances for one patient.

Sarz Maxwell, Chicago – controlled substance license issued on probation due to medical license being previously disciplined by the department.

John W. Otten, Peoria – controlled substance license reprimanded for prescribing Dexedrine 10 mg Spansules for his spouse for approximately five years without maintaining medical records.

PRAVACHOL®

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CONTRAINDICATIONS: Hypersensitivity to any component of this medication. Active liver disease or unexplained, persistent elevations in liver function tests (see **WARNINGS**). *Pregnancy and lactation.* Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. Cholesterol and other products of cholesterol biosynthesis are essential components for fetal development (including synthesis of steroids and cell membranes). Since HMG-CoA reductase inhibitors decrease cholesterol synthesis and possibly the synthesis of other biologically active substances derived from cholesterol, they may cause fetal harm when administered to pregnant women. Therefore, HMG-CoA reductase inhibitors are contraindicated during pregnancy and in nursing mothers. Pravastatin should be administered to women of childbearing age only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the patient becomes pregnant while taking this class of drug, therapy should be discontinued and the patient apprised of the potential hazard to the fetus. **WARNINGS: Liver Enzymes** — HMG-CoA reductase inhibitors, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Increases of serum transaminase (ALT, AST) values to more than 3 times the upper limit of normal occurring on 2 or more (not necessarily sequential) occasions have been reported in 1.3% of patients treated with pravastatin in the US over an average period of 18 months. These abnormalities were not associated with cholestasis and did not appear to be related to treatment duration. In those patients in whom these abnormalities were believed to be related to pravastatin and who were discontinued from therapy, the transaminase levels usually fell slowly to pretreatment levels. These biochemical findings are usually asymptomatic although worldwide experience indicates that anorexia, weakness, and/or abdominal pain may also be present in rare patients. It is recommended that liver function tests be performed before the initiation of treatment, at 6 and 12 weeks after initiation of therapy or elevation in dose, and periodically thereafter (e.g., semiannually). Patients who develop increased transaminase levels should be monitored with a second liver function evaluation to confirm the finding and be followed thereafter with frequent liver function tests until the abnormality(ies) return to normal. Should an increase in AST or ALT of three times the upper limit of normal or greater persist, withdrawal of pravastatin therapy is recommended. Active liver disease or unexplained transaminase elevations are contraindications to the use of pravastatin (see **CONTRAINDICATIONS**). Caution should be exercised when pravastatin is administered to patients with a history of liver disease or heavy alcohol ingestion (see **CLINICAL PHARMACOLOGY: Pharmacokinetics/Metabolism**). Such patients should be closely monitored, started at the lower end of the recommended dosing range, and titrated to the desired therapeutic effect. **Skeletal Muscle** — Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with pravastatin and other drugs in this class. Uncomplicated myalgia has also been reported in pravastatin-treated patients (see **ADVERSE REACTIONS**). Myopathy, defined as muscle aching or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values to greater than 10 times the upper normal limit, was rare (< 0.1%) in pravastatin clinical trials. Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. Pravastatin therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. Pravastatin therapy should also be temporarily withheld in any patient experiencing an acute or serious condition predisposing to the development of renal failure secondary to rhabdomyolysis, e.g., sepsis; hypotension; major surgery; trauma; severe metabolic, endocrine, or electrolyte disorders; or uncontrolled epilepsy. The risk of myopathy during treatment with another HMG-CoA reductase inhibitor is increased with concurrent therapy with either erythromycin, cyclosporine, niacin, or fibrates. However, neither myopathy nor significant increases in CPK levels have been observed in three reports involving a total of 100 post-transplant patients (24 renal and 76 cardiac) treated for up to two years concurrently with pravastatin 10-40 mg and cyclosporine. Some of these patients also received other concomitant immunosuppressive therapies. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine. Further, in clinical trials involving small numbers of patients who were treated concurrently with pravastatin and niacin, there were no reports of myopathy. Also, myopathy was not reported in a trial of combination pravastatin (40 mg/day) and gemfibrozil (1200 mg/day), although 4 of 75 patients on the combination showed marked CPK elevations versus one of 73 patients receiving placebo. There was a trend toward more frequent CPK elevations and patient withdrawals due to musculoskeletal symptoms in the group receiving combined treatment as compared with the groups receiving placebo, gemfibrozil, or pravastatin monotherapy (see **PRECAUTIONS: Drug Interactions**). The use of fibrates alone may occasionally be associated with myopathy. The combined use of pravastatin and fibrates should be avoided unless the benefit of further alterations in lipid levels is likely to outweigh the increased risk of this drug combination. **PRECAUTIONS: General** — Pravastatin may elevate creatinine phosphokinase and transaminase levels (see **ADVERSE REACTIONS**). This should be considered in the differential diagnosis of chest pain in a patient on therapy with pravastatin. *Homozygous Familial Hypercholesterolemia.* Pravastatin has not been evaluated in patients with rare homozygous familial hypercholesterolemia. In this group of patients, it has been reported that HMG-CoA reductase inhibitors are less effective because the patients lack functional LDL receptors. *Renal Insufficiency.* A single 20 mg oral dose of pravastatin was administered to 24 patients with varying degrees of renal impairment (as determined by creatinine clearance). No effect was observed on the pharmacokinetics of pravastatin or its 3 α -hydroxy isomeric metabolite (SQ 31,906). A small increase was seen in mean AUC values and half-life ($t_{1/2}$) for the inactive enzymatic ring hydroxylation metabolite (SQ 31,945). Given this small sample size, the dosage administered, and the degree of individual variability, patients with renal impairment who are receiving pravastatin should be closely monitored. **Information for Patients** — Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. **Drug Interactions** — *Immunosuppressive Drugs, Gemfibrozil, Niacin (Nicotinic Acid), Erythromycin:* See **WARNINGS: Skeletal Muscle.** *Antipyridine:* Since concomitant administration of pravastatin had no effect on the clearance of antipyridine, interactions with other drugs metabolized via the same hepatic cytochrome isozymes are not expected. *Cholestyramine/Colestipol:* Concomitant administration resulted in an approximately 40 to 50% decrease in the mean AUC of pravastatin. However, when pravastatin was administered 1 hour before or 4 hours after cholestyramine or colestipol before a standard meal, there was no clinically significant decrease in bioavailability or therapeutic effect. (See **DOSE AND ADMINISTRATION: Concomitant Therapy**.) *Warfarin:* In a study involving 10 healthy male subjects given pravastatin and warfarin concomitantly for 6 days, bioavailability parameters at steady state for pravastatin (parent compound) were not altered. Pravastatin did not alter the plasma protein-binding of warfarin. Concomitant dosing did increase the AUC and Cmax of warfarin but did not produce any changes in its anticoagulant action (i.e., no increase was seen in mean prothrombin time after 6 days of concomitant therapy). However, bleeding and extreme prolongation of prothrombin time has been reported with another drug in this class. Patients receiving warfarin-type anticoagulants should have their prothrombin times closely monitored when pravastatin is initiated or the dosage of pravastatin is changed. *Cimetidine:* The AUC_{0-12 hr} for pravastatin when given with cimetidine was not significantly different from the AUC for pravastatin when given alone. A significant difference was observed between the AUC's for pravastatin when given with cimetidine compared to when administered with antacid. *Digoxin:* In a crossover trial involving 18 healthy male subjects given pravastatin and digoxin concurrently for 9 days, the bioavailability parameters of digoxin were not affected. The AUC of pravastatin tended to increase, but the overall bioavailability of pravastatin plus its metabolites SQ 31,906 and SQ 31,945 was not altered. *Cyclosporine:* Some investigators have measured cyclosporine levels in patients on pravastatin, and to date, these results indicate no clinically meaningful elevations in cyclosporine levels. In one single-dose study, pravastatin levels were found to be increased in cardiac transplant patients receiving cyclosporine. *Gemfibrozil:* In a crossover study in 20 healthy male volunteers given concomitant single doses of pravastatin and gemfibrozil, there was a significant decrease in urinary excretion and protein binding of pravastatin. In addition, there was a significant increase in AUC, Cmax, and Tmax for the pravastatin metabolite SQ 31,906. Combination therapy with pravastatin and gemfibrozil is generally not recommended. In interaction studies with *aspirin, antacids* (1 hour prior to PRAVACHOL), *cimetidine, nicotinic acid, or probucol*, no statistically significant differences in bioavailability were seen when PRAVACHOL (pravastatin sodium) was administered. *Other Drugs:* During clinical trials, no noticeable drug interactions were reported when PRAVACHOL was added to: diuretics, antihypertensives, digitalis, ACE inhibitors, calcium channel blockers, beta-blockers, or nitroglycerin. **Endocrine Function** — HMG-CoA reductase inhibitors interfere with cholesterol synthesis and lower circulating cholesterol levels and, as such, might theoretically blunt adrenal or gonadal steroid hormone production. Results of clinical trials with pravastatin in males and post-menopausal females were inconsistent with regard to possible effects of the drug on basal steroid hormone levels. In a study of 21 males, the mean testosterone response to human chorionic gonadotropin was significantly reduced ($p < 0.004$) after 16 weeks of treatment with 4J mg of pravastatin. However, the percentage of patients showing a $\geq 50\%$ rise in plasma testosterone after human chorionic gonadotropin stimulation did not change significantly after therapy in these patients. The effects of HMG-CoA reductase inhibitors on spermatogenesis and fertility have not been studied in adequate numbers of patients. The effects, if any, of pravastatin on the pituitary-gonadal axis in pre-menopausal females are unknown. Patients treated with pravastatin who display clinical evidence of endocrine dysfunction should be evaluated appropriately. Caution should also be exercised if an HMG-CoA reductase inhibitor or other agent used to lower cholesterol levels is administered to patients also receiving other drugs (e.g., ketoconazole, spironolactone, cimetidine) that may diminish the levels or activity of steroid hormones. **CNS Toxicity** — CNS vascular lesions, characterized by perivascular hemorrhage and edema and mononuclear cell infiltration of perivascular spaces, were seen in dogs treated with pravastatin at a dose of 25 mg/kg/day, a dose that produced a plasma drug level about 50 times higher than the mean drug level in humans taking 40 mg/day. Similar CNS vascular lesions have been observed with several other drugs in this class. A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion starting at 60 mg/kg/day, a dose that produced mean plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose (as measured by total enzyme inhibitory activity). This same drug also produced vestibulocochlear (Wallerian-like degeneration of retinal ganglion cell chromatolysis) in dogs treated for 14 weeks at 180 mg/kg/day, a dose which resulted in a mean plasma drug level similar to that seen with the 60 mg/kg/day dose. **Carcinogenesis, Mutagenesis, Impairment of Fertility** — In a 2-year study in rats fed pravastatin at doses of 10, 30, or 100 mg/kg body weight, there was an increased incidence of hepatocellular carcinomas in males at the highest dose ($p < 0.01$). Although rats were given up to 125 times the human dose (H₀) on a mg/kg body weight basis, serum drug levels were only 6 to 10 times higher than

those measured in humans given 40 mg pravastatin as measured by AUC. The oral administration of 10, 30, or 100 mg/kg (producing plasma drug levels approximately 0.5 to 5.0 times the human drug levels at 40 mg) of pravastatin to mice for 22 months resulted in a statistically significant increase in the incidence of malignant lymphomas in treated females when all treatment groups were pooled and compared to controls ($p < 0.05$). The incidence was not dose-related and male mice were not affected. A chemically similar drug in this class was administered to mice for 72 weeks at 25, 100, and 400 mg/kg body weight, which resulted in mean serum drug levels approximately 3, 15, and 33 times higher than the mean human serum drug concentration (as total inhibitory activity) after a 40 mg oral dose. Liver carcinomas were significantly increased in high-dose females and mid- and high-dose males, with a maximum incidence of 90 percent in males. The incidence of adenomas of the liver was significantly increased in mid- and high-dose females. Drug treatment also significantly increased the incidence of lung adenomas in mid- and high-dose males and females. Adenomas of the eye Harderian gland (a gland of the eye of rodents) were significantly higher in high-dose mice than in controls. No evidence of mutagenicity was observed *in vitro*, with or without rat-liver metabolic activation, in the following studies: microbial mutagen tests, using mutant strains of *Salmonella typhimurium* or *Escherichia coli*; a forward mutation assay in L5178Y TK +/- mouse lymphoma cells; a chromosomal aberration test in hamster cells; and a gene conversion assay using *Saccharomyces cerevisiae*. In addition, there was no evidence of mutagenicity in either a dominant lethal test in mice or a micronucleus test in mice. In a study in rats, with daily doses up to 500 mg/kg, pravastatin did not produce any adverse effects on fertility or general reproductive performance. However, in a study with another HMG-CoA reductase inhibitor, there was decreased fertility in male rats treated for 34 weeks at 25 mg/kg body weight, although this effect was not observed in a subsequent fertility study when this same dose was administered for 11 weeks (the entire cycle of spermatogenesis, including epididymal maturation). In rats treated with this same reductase inhibitor at 180 mg/kg/day, seminiferous tubule degeneration (necrosis and loss of spermatogenic epithelium) was observed. Although not seen with pravastatin, two similar drugs in this class caused drug-related testicular atrophy, decreased spermatogenesis, spermatocytic degeneration, and giant cell formation in dogs. The clinical significance of these findings is unclear. **Pregnancy: Pregnancy Category X.** — See **CONTRAINDICATIONS**. Safety in pregnant women has not been established. Pravastatin was not teratogenic in rats at doses up to 1000 mg/kg daily or in rabbits at doses of up to 50 mg/kg daily. These doses resulted in 20x (rabbit) or 240x (rat) the human exposure based on surface area (mg/meter²). However, in studies with another HMG-CoA reductase inhibitor, skeletal malformations were observed in rats and mice. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (Vater association) in a baby born to a woman who took another HMG-CoA reductase inhibitor with dextroamphetamine sulfate during the first trimester of pregnancy. PRAVACHOL (pravastatin sodium) should be administered to women of child-bearing potential only when such patients are highly unlikely to conceive and have been informed of the potential hazards. If the woman becomes pregnant while taking PRAVACHOL (pravastatin sodium), it should be discontinued and the patient advised again as to the potential hazards to the fetus. **Nursing Mothers** — A small amount of pravastatin is excreted in human breast milk. Because of the potential for serious adverse reactions in nursing infants, women taking PRAVACHOL should not nurse (see **CONTRAINDICATIONS**). **Pediatric Use** — Safety and effectiveness in individuals less than 18 years old have not been established. Hence, treatment in patients less than 18 years old is not recommended at this time. **ADVERSE REACTIONS:** Pravastatin is generally well tolerated; adverse reactions have usually been mild and transient. In 4-month long placebo-controlled trials, 1.7% of pravastatin-treated patients and 1.2% of placebo-treated patients were discontinued from treatment because of adverse experiences attributed to study drug therapy; this difference was not statistically significant. In long-term studies, the most common reasons for discontinuation were asymptomatic serum transaminase increases and mild, non-specific gastrointestinal complaints. During clinical trials, the overall incidence of adverse events in the elderly was not different from the incidence observed in younger patients. **Adverse Clinical Events** — All adverse clinical events (regardless of attribution) reported in more than 2% of pravastatin-treated patients in the placebo-controlled trials are identified in the table below; also shown are the percentages of patients in whom these medical events were believed to be related or possibly related to the drug:

Body System/Event	All Events		Events Attributed to Study Drug	
	Pravastatin (N = 900) %	Placebo (N = 411) %	Pravastatin (N = 900) %	Placebo (N = 411) %
Cardiovascular				
Cardiac Chest Pain	4.0	3.4	0.1	0.0
Cardiologic Rash	4.0*	1.1	1.3	0.9
Gastrointestinal				
Nausea/Vomiting	7.3	7.1	2.9	3.4
Diarrhea	6.2	5.6	2.0	1.9
Abdominal Pain	5.4	6.9	2.0	3.9
Constipation	4.0	7.1	2.4	5.1
Flatulence	3.3	3.6	2.7	3.4
Heartburn	2.9	1.9	2.0	0.7
General				
Fatigue	3.8	3.4	1.9	1.0
Chest Pain	3.7	1.9	0.3	0.2
Influenza	2.4*	0.7	0.0	0.0
Musculoskeletal				
Localized Pain	10.0	9.0	1.4	1.5
Myalgia	2.7	1.0	0.6	0.0
Nervous System				
Headache	6.2	3.9	1.7*	0.2
Dizziness	3.3	3.2	1.0	0.5
Renal/Genitourinary				
Urinary Abnormality	2.4	2.9	0.7	1.2
Respiratory				
Common Cold	7.0	6.3	0.0	0.0
Rhininitis	4.0	4.1	0.1	0.0
Cough	2.6	1.7	0.1	0.0

*Statistically significantly different from placebo.

In the Pravastatin Primary Prevention Study (West of Scotland Coronary Prevention Study) (see **CLINICAL PHARMACOLOGY: Clinical Studies**) involving 6595 patients treated with PRAVACHOL (pravastatin sodium) (N = 3302) or placebo (n = 3293) the adverse event profile in the pravastatin group was comparable to that of the placebo group over the median 4.8 years of the study. The following effects have been reported with drugs in this class; not all the effects listed below have necessarily been associated with pravastatin therapy: *Skeletal:* myopathy, rhabdomyolysis, arthralgia. *Neurological:* dysfunction of certain cranial nerves (including alteration of taste, impairment of extra-ocular movement, facial paresis), tremor, vertigo, memory loss, paresthesia, peripheral neuropathy, peripheral nerve palsy, anxiety, insomnia, depression. *Hypersensitivity Reactions:* An apparent hypersensitivity syndrome has been reported rarely which has included one or more of the following features: anaphylaxis, angioedema, lupus erythematosus-like syndrome, polymyalgia rheumatica, dermatomyositis, vasculitis, purpura, thrombocytopenia, leukopenia, hemolytic anemia, positive ANA, ESR increase, eosinophilia, arthritis, arthralgia, urticaria, asthenia, photosensitivity, fever, chills, flushing, malaise, dyspnea, toxic epidermal necrolysis, erythema multiforme, including Stevens-Johnson syndrome. *Gastrointestinal:* pancreatitis, hepatitis, including chronic active hepatitis, cholestatic jaundice, fatty change in liver, and, rarely, cirrhosis, fulminant hepatic necrosis, and hepatoma; anorexia, vomiting. *Skin:* alopecia, pruritus. A variety of skin changes (e.g., nodules, discoloration, dryness of skin/mucous membranes, changes to hair/nails) have been reported. *Reproductive:* gynecomastia, loss of libido, erectile dysfunction. *Eye:* progression of cataracts (lens opacities), ophthalmoplegia. *Laboratory Abnormalities:* elevated transaminases, alkaline phosphatase, and bilirubin; thyroid function abnormalities. **Laboratory Test Abnormalities** — Increases in serum transaminase (ALT, AST) values and CPK have been observed (see **WARNINGS**). Transient, asymptomatic eosinophilia has been reported. Eosinophil counts usually returned to normal despite continued therapy. Anemia, thrombocytopenia, and leukopenia have been reported with HMG-CoA reductase inhibitors. **Concomitant Therapy** — Pravastatin has been administered concurrently with cholestyramine, colestipol, nicotinic acid, probucol and gemfibrozil. Preliminary data suggest that the addition of either probucol or gemfibrozil to therapy with lovastatin or pravastatin is not associated with greater reduction in LDL-cholesterol than that achieved with lovastatin or pravastatin alone. No adverse reactions unique to the combination or in addition to those previously reported for each drug alone have been reported. Myopathy and rhabdomyolysis (with or without acute renal failure) have been reported when another HMG-CoA reductase inhibitor was used in combination with immunosuppressive drugs, gemfibrozil, erythromycin, or lipid-lowering doses of nicotinic acid. Concomitant therapy with HMG-CoA reductase inhibitors and these agents is generally not recommended. (See **WARNINGS: Skeletal Muscle** and **PRECAUTIONS: Drug Interactions**). **OVERDOSAGE:** To date, there are two reported cases of overdose with pravastatin, both of which were asymptomatic and not associated with clinical laboratory abnormalities. If an overdose occurs, it should be treated symptomatically and supportive measures should be instituted as required.

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Physicians can help put a lid on teen drinking

Alcohol is still the drug of choice for young people.

BY DEBORAH PREISER

It's party time for America's youth, and even though there's been a sharp upswing in marijuana usage among high school students, teens are continuing to make alcohol their drug of choice. In fact, when the National Institute on Drug Abuse surveyed more than 15,000 high school seniors last year, nearly 74 percent reported drinking alcohol in the past 12 months. And more than half of the seniors surveyed had been drunk during that time period, according to NIDA's annual study.

Alcohol is even more popular among college students. When the Core Institute at Southern Illinois University surveyed more than 38,000 men and women at 77 colleges about their alcohol and drug usage, 85 percent said they had drunk alcohol in the past year.

Why the continuing trend? "There's a Nobel Prize for the person who can answer that definitively," said Gerald Suchomski, MD, vice chairman and director of predoctoral education for the Department of Family and Community Medicine at the Southern Illinois University School of Medicine in Springfield. "There are two schools of thought. One says there is a cycle of increased and decreased use, independent of anything else. The other suggests the exposure that today's kids get to drugs and alcohol is much more graphic, via TV and the other media. There is a feeling of comfort, a degree of familiarity, with these substances. And kids have always wanted to experiment."

Dr. Suchomski, a member of the ISMS Council on Mental Health and Addiction, said he believes physicians should more actively screen teens and young adults for addictive behaviors. They could use their interactions with young adults, perhaps during required school or team physical exams, to broach potential problems, he said.

What should doctors ask? They can use a quick screening tool like the CAGE questionnaire, published in the Journal of the American Medical Association in 1984 and "very much underutilized," Dr. Suchomski

said. Each letter in CAGE corresponds to one of the four questions to ask patients: Have you ever tried to "cut down" on drinking? Have you ever been "annoyed" by other people criticizing your drinking? Have you ever felt "guilty" about drinking? Have you ever needed an "eye-opener drink" to get started for the day? "The true art is working the CAGE questions into a social history without the patient's ever knowing you're screening for a problem with alcohol," he said. That, simply put, takes practice.

Any physician who does identify a problem should offer to assist the patient in getting help, said Dr. Suchomski. "If you learn that a 21-year-old college student is drinking 12 beers a week, you want to find out when they're drinking that beer. If it's all on Friday night, you want to counsel them to make a shift in their drinking pattern that's less dangerous." Suggest that the student drink fewer beers spread out over more days and some of the time switch to a non-alcoholic beer, he said. A doctor should help a patient recognize a serious drinking problem and offer the phone numbers of outpatient clinics or groups like Alcoholics Anonymous, Dr. Suchomski advised.

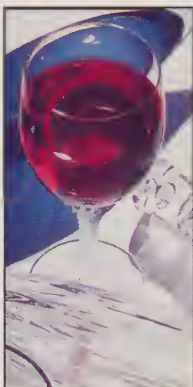
Marty Doot, MD, chief of addiction medicine at Lutheran General Hospital in Park Ridge, echoed Dr. Suchomski's sentiments that physicians should screen young people and adults for substance abuse. "They have to get comfortable about asking the right questions regarding a patient's level of involvement," he said.

Dr. Doot, who is medical director for the ISMS Physician Assistance Program, recommended as a resource the second edition of the AMA's "Guidelines for Adolescent Preventive Services." The guidelines advise primary care physicians and other health care providers to evaluate regularly their patients aged 11 to 21 to screen for health risk behaviors and offer guidance to help them cope with developmental challenges, maintain healthy lifestyles, improve diet and fitness and prevent injury.

(Continued on page 10)



inset photos: ©Garry Gay/Image Bank



Physicians can help

(Continued from page 9)

In addition, the guidelines suggest that physicians involve parents or guardians of their young patients by periodically discussing normal adolescent development, signs and symptoms of substance-abuse-related disease and emotional distress. The guide also covers parenting skills that promote healthy adolescent adjustment, a key to preventing substance abuse, Dr. Doot said.

Another approach that shows promise is mentoring through peers, according to Dr. Suchomski. Peer influ-

ence is an integral part of the "Risky Business" outreach program begun seven years ago by orthopedic nurse Mary Kay Griffin, also of the SIU School of Medicine, and Shannon Stauffer, MD, professor of orthopedics at the SIU School of Medicine and medical director of the Spinal Cord Injury Department at Memorial Medical Center in Springfield. Griffin said she visits area junior high and high schools with a young spinal-cord-injury patient, usually the victim of an auto or diving accident related to alcohol consumption. Through the program, which is funded by the Illinois Department of Transportation, 55,000

central Illinois students have seen 362 presentations during the past six years.

"We can walk into a gym with 1,000 noisy students and think they'll never quiet down," Griffin said. "But once the young presenter, who's survived a serious, usually preventable accident, starts talking, the audience listens. Our presenters often bring pictures of themselves before the accident and tell stories about the kinds of things they used to do. These are all basically good kids — personable, popular, athletic. They usually say they knew what they were doing was stupid, but they did it anyway. They show the catheters they have to use on themselves

to go the bathroom. That always gets attention. The audience may not say much, but you can see it hit home by watching their faces."

Also during the program, Griffin shares statistics and demonstrates feeding tubes, breathing tubes and other medical equipment that helps the survivors to function. She also invites paramedics and police officers to add their perspectives on alcohol-related accidents. "We don't want to preach to kids," she said. "We just give them the facts, show them the results of bad decisions and say the rest is up to them."

Clearly there is a need for such programs. Of the 6,220 people aged 15 to 20 who died in car crashes nationwide in 1995, 2,206 of their deaths, or 35.5 percent, were related to alcohol. Thousands of other young people were left with serious lifelong injuries from auto accidents. In Illinois, alcohol-related traffic deaths increased last year for the first time since 1989, reflecting a national trend. According to the National Highway Traffic Safety Administration, 42.9 percent of the 1,586 highway deaths in Illinois during 1995 involved alcohol.

BINGE DRINKING, defined as consuming five or more alcoholic beverages at one sitting, increases the chances of an accident. A recent Harvard University study showed that hard-drinking college students are more likely to drive while intoxicated or ride with a drunken driver. That poll of nearly 18,000 students at 140 U.S. colleges in 1993 showed that binge-drinking college students are four times more likely than their lighter-drinking peers to drive after consuming alcohol. And while only about 7 percent of the light drinkers said they would ride with a driver who was high or drunk, about half of the binge drinkers indicated they would.

To help instill greater responsibility in students, Eastern Illinois University in Charleston developed the "Convincer," a simulator that lets students experience what it's like to be in a low-speed car crash.

Through a University of Illinois at Champaign program, student volunteers offer rides to peers who have been drinking, who don't want to ride with a drunken driver or who want to avoid the possibility of being a crime victim. The student-run program recently affiliated with the National Group Rides and Designated Drivers program. (See sidebar, page 11.)

Evanston-based Northwestern University has instituted a number of programs to discourage substance abuse among staff as well as students. In the past year, 50 faculty-member "Natural Helpers" volunteers have been trained to recognize the warning signs of substance abuse, and they have made 68 student and faculty referrals to the university's health center since the program began, according to Sandy Derks, co-director of health education at NU.

The U.S. Department of Education provided NU with a grant that has helped train 35 student volunteers as "chemical health" peer educators. They run a drop-in center for fellow students seeking information and advice about substance abuse.

A federal grant also funds a consortium project for Northwestern, Loyola University in Chicago and the University of Illinois at Chicago. Through the program, 70 student volunteers have been trained to help educate younger students

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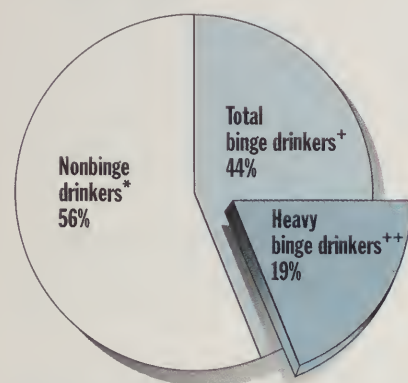
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Binge drinking on campus

A survey of 17,592 undergraduate students at 140 U.S. 4-year colleges in 1993



*Students who consumed alcohol in the past year but did not binge

+Women who consumed four or more drinks and men who consumed five or more drinks in a two-week period

++Students who binged three or more times in a two-week period

Source: JAMA, Dec. 7, 1994; Vol. 272, No. 21

in Chicago about substance abuse and violence prevention.

Clearly, there is a concerted effort among physicians, schools and students to deal with teen alcohol abuse. The literature, however, points to the family as the starting point, according to Dr. Doot. "Kids have to get through adolescence with strong reassurances from their family that they are important, significant people. No parent should deny the possibility that their child may experiment with drugs or alcohol. The key is early intervention." ■

Program gives college students a responsible choice

The National Group Rides and Designated Drivers program has accomplished a lot for a young, basically one-woman operation. Established with little more than a wish and a prayer in 1993 by Kristin Crawford, then a 21-year-old University of Florida senior, the nonprofit group now has 31 colleges participating by offering safe ride programs for students who may have had too much to drink or don't want to ride with a drunken driver. Crawford, now executive director and sole employee, helps individual student-run programs get established, win the acceptance of university officials and receive funding.

"Despite the fact that there are campaigns and signs all over campuses, students do drink and drive," said Crawford when she began the program. "There needs to be some kind of program at each university so that if students do choose to drink, they can also choose a responsible alternative to driving under the influence." Some schools use shuttles; others work out programs with local cab companies or public transit systems; and smaller groups of students might even implement a simple pager or designated-driver system, Crawford said in an interview with Illinois Medicine.

She has never lost a friend or relative to drunken driving, but Crawford said she feels passionately that free or low-cost rides can save the lives of many college students. Her philosophy is that while other national groups work on alcohol-related education and legalities, her group works directly on a solution to the drunken college student who poses a danger behind the wheel.

Crawford said she hopes to add a physician to the six-member board of directors that meets four times a year. "We have a lot of different views," she said of the board members, who are the president and CEO of a large Chicago-based corporation, two people with wide experience in the nonprofit and philanthropic sectors, a college president, an attorney and the former director of a university safe-ride program. "But we seem to miss the health side of this. I'd love to get someone who could come to the table with new ideas or contacts in the medical field. We want to build a diverse board to contribute ideas and thoughts to build the best possible network we can."

National GRADD was started with a \$28,000 donation from a LaGrange accountant who read about Crawford's idea in an article in the St. Petersburg

(Florida) Times. Later a Los Angeles-based group that's funded by the California beverage and alcohol industry and works on alcohol-related problems gave her a \$40,000 grant. She used that to create the National GRADD Model Programs Booklet, a 180-page publication for students and administrators to use when they consider whether to start a safe-ride program.

Crawford recently negotiated a deal with a Chicago travel agency and bookstore, whereby a percentage of the money they make from sales will go to the National GRADD program, with some money going to a college of the consumer's choice. The Dr. Pepper company recently agreed to put the program on its Web site, she said, and the State Farm insurance company recently sent an e-mail to its agents throughout the nation asking them to get involved with the program.

She has lots of plans for expansion, "but we really need to expand our funding base," said Crawford, who explained that the major financial backer may soon cut funding. Physicians interested in becoming a board member or contributing to National GRADD may contact the group at P.O. Box 48008, St. Petersburg, FL 33743-8008; telephone (813) 546-7233. The e-mail address is ntlgradd@ix.netcom.com.

— Wendy Anderson

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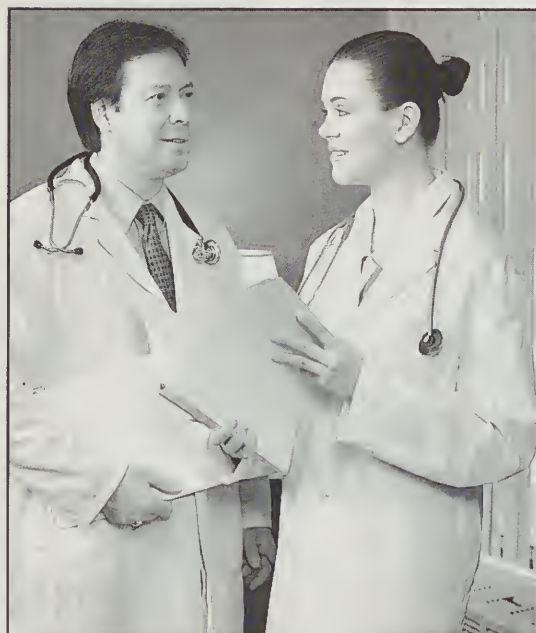
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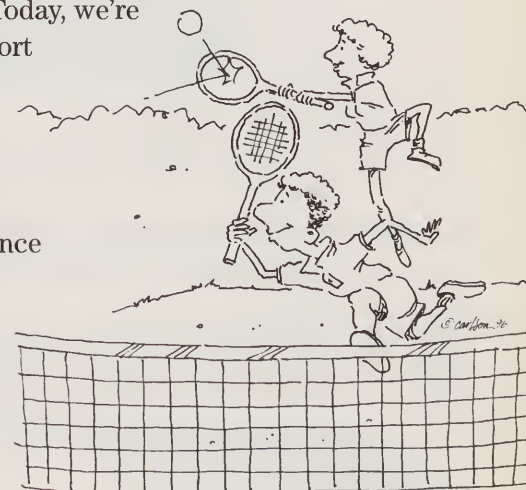
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(Continued from page 1)

tim of violence, according to Dr. May. Other risks, particularly if they occur before high school years, include seeing a shooting, contracting a sexually transmitted disease, spending time in jail and having access to a semiautomatic weapon.

The ICPV was behind passage of the Illinois Violence Prevention Act of 1995. The act, which passed the Illinois General Assembly without a single "no" vote, established the Illinois Violence Prevention Authority to plan, coordinate, fund and evaluate approaches to violence prevention in the state. The act is a "clear commitment at the state level to the prevention of violence from a public health and public safety approach," said Barbara Shaw, ICPV's executive director.

CONFERENCE ATTENDEES received a fact sheet including the following statistics from the Illinois Criminal Justice Authority: In 1995, there were 1,221 murders in Illinois, 824 of which were in Chicago. Firearms caused 74 percent of the homicide deaths in Chicago in 1993 and 1994. In Illinois, more than 7,238 sexual assaults were reported in 1995, and the FBI estimates that only one in 10 sexual assaults is reported. A Community Mental Health Council survey found that of 203 black high school freshmen in Chicago, about 45 percent had seen someone killed; 66 percent had witnessed a shooting; 49

percent had been shot at; 38 percent had seen someone stabbed; 9 percent had been stabbed; and 7 percent had been raped.

"It is everybody's responsibility to help prevent violence and to help interrupt the cycle of violence," said Gail Williamson, MD, a member of ISMS and the ICPV. The AMA has published a series of seven books detailing how physicians can approach violence issues such as sexual or domestic abuse, Dr. Williamson said. Book topics include how physicians can get patients to open up about violence and what signs to look for when determining whether a patient has suffered from domestic violence.

Dr. Williamson also discussed a packet available to Illinois physicians through the anti-violence initiative "Stop Domestic Violence Before It's Too Late," which was developed by ISMS and the ISMS Alliance. The packet provides physician-specific information including a resource list, a family stress test brochure and a video program detailing what physicians can do, Dr. Williamson said. "It stresses very clearly to a physician and other professionals who deal with these patients that you are not the sole responsible person," she said. "You need to identify [the violence] and refer the person on to resources." For more information about the packet, physicians may call (312) 782-2099.

Dr. May said he uses the mnemonic device "guns" to remind himself to ask specific questions of patients about vio-

SHOPPER Ruth Hagge (right) receives a bonus at the Quincy Mall on Sept. 29 – a handout on breast cancer from Adams County Medical Society Alliance member Lornar Vollmer. The alliance sponsored a reception and exhibit to increase awareness of the disease.



Duane Nichols/Photo Network

lence in their lives. G stands for gun. Do patients have a gun at home? If so, that increases the chance that they will experience violence. U represents use. Does someone in the home use alcohol or other drugs? That is another risk factor. N is for need. Do patients feel the need to protect themselves? And S stands for three different situations: Has the person "seen" or been involved in acts of violence? Has the person experienced "sadness"? Are there "school-age children" or adolescents in the home? Those suffering from great sadness may be at an increased risk for suicide, he said, and having children in the home increases the risk that they are involved in gangs and could have guns around the house.

"We can address violence," said Dr. May, "just as we address any other [health] problems." ■

Medical Advisory

(Continued from page 3)

The board's determination is provided to the driver, who has 20 days to request a formal review to contest the result, Novak said. A panel composed of the physician who made the informal recommendation, the chairman and another physician hears an appeal from the motorist and makes a recommendation, Dr. Norbury said.

Drivers who still don't accept the panel's recommendation can request an administrative hearing, Dr. Norbury said.

Physicians or license applicants may pick up medical reports at any driver's license facility. Completed forms may be mailed to Driver's Services, Medical Review Unit, 2701 S. Dirksen Parkway, Springfield, IL 62763. For more information, call (217) 785-1095 ■

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AMA to implement

(Continued from page 1)

medical societies have already begun some aspects of AMAP." The Oregon Medical Association, for instance, established a single program for site reviews more than a year ago that has been accepted by all the managed care companies in the state. "In Massachusetts, the state medical society's Credentialing Verification Organization has already accredited 6,000 physicians in the state," Dr. Jessee said.

An AMA spokesperson said the AMA wants to work with state medical societies and, if appropriate, even contract with those that have existing programs whose functions mesh with those of AMAP.

Dr. Jessee's staff has been working with the credentialing organizations of various state medical societies to design a nationally standardized credentialing form acceptable to managed care plans, hospitals and entities that do medical accreditation across the country. "We have to create an accreditation process that meets the needs of everyone," Dr. Jessee said. "Before we even offer AMAP to physicians, we must have agreements in place with the managed care organizations in that state saying they will accept AMAP accreditation. We don't want our doctors buying a pig in a poke."

We have to create an accreditation process that meets the needs of everyone.

"Everybody realizes that the current system of each managed care entity doing its own credentialing, office and medical record reviews is inefficient," said the AMA spokesperson. "Physicians, as well as the managed care companies, are anxious to see what the accreditation program will look like. With input from all interested parties, we expect that everyone will be pleased with a system that is a more streamlined, efficient and reliable way to evaluate physicians."

Although the program is voluntary, the AMA anticipates that most physicians will want to participate to gain the AMA "seal of approval," the ultimate standard in quality health care, according to the spokesperson.

The program will assess physician performance in five areas. The first is credentials – education, licensure and disciplinary actions taken against the doctor.

The second area, personal qualifications, involves agreement to abide by the AMA Code of Ethics and by standardized patient complaint and grievance procedures. Required under this component will be participation in an organization that conducts peer review and completion of relevant continuing medical education and an annual self-assessment program.

Third is the care environment, which necessitates on-site review of the clinical, operational and management systems in a physician's office. Evaluators will assess the physical facilities, the documentation of medical records, the diagnostic and

testing policies and procedures and the office management systems.

In the fourth area, clinical performance, accredited physicians will receive and review information about their clinical performance compared with national benchmarks that will be developed by the specialty societies. In addition, doctors will be given suggestions for improvement. That evaluation will serve as an educational feedback exercise for physicians, thereby improving the quality of care that patients receive, according to AMA background material.

Finally, patient care results will be

determined by patient satisfaction surveys as well as objective measurements of clinical outcomes and health status.

AMAP will be developed in large measure through collaborative relationships with state and county medical societies and specialty societies, Dr. Jessee said. Medical societies will be the preferred contractors for verifying applicants' credentials and conducting office visits, according to the AMA. Specialty societies will help design the self-assessment portion of the program.

Although there are already several health care accrediting groups, no formal group has ever been responsible for

accrediting physicians. The AMA is a logical choice to accredit physicians, according to Dr. Jessee. "Doctors know what good doctoring is," he said.

The AMA is still studying how to finance AMAP, Dr. Jessee said. Physicians will probably be charged a modest fee – about \$50 for AMA members and more for nonmembers. "The real cost will not be supported by physicians, but by the fees paid by managed care organizations, hospitals and other groups that request this information," he explained. "With our economies of scale, it will probably cost them less than they are spending now." ■

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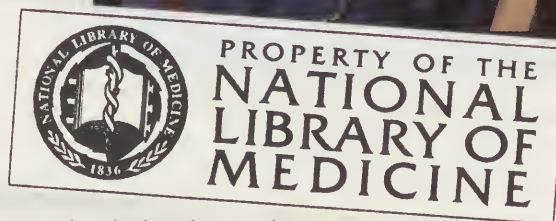
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PAGE 2



Ron Ackerman

VOLUNTEER DEB ANDERSON hands a "ballot" to student Derek Ackerman in Springfield on election day. Both participated in Kids Voting USA, a privately funded program that educates youngsters from kindergarten through 12th grade about the importance of voting to sustain a democracy.

State Democrats get House, Republicans keep Senate

GENERAL ELECTION: Party control of the Illinois General Assembly splits. BY JANE ZENTMYER

[CHICAGO] In the 1996 General Election, Democrats took control of the Illinois House and the U.S. Senate seat vacated by Paul Simon while Republicans held on to the Illinois Senate with a slim majority. While the shift of power in the Illinois House dims future hopes for state tort reform, other health-care-related legislation typically has supporters regardless of which party is in power.

"ISMS and its member physicians are interested in working with every individual legislator to improve health care services in Illinois," said ISMS President Sandra Olson, MD. "This is a time of great change for physicians and the health care delivery system, and the government will play an important role in those changes. ISMS will continue to be a strong advocate for physicians and patients and will keep letting legislators know how bills would affect both groups."

In the Illinois House, the Illinois Medical Political Action Committee supported 110 candidates, of whom 104 were winners. In the Senate, 39 seats were open, and IMPAC supported all but two of the winners. "In addition to supporting

candidates friendly to medicine, IMPAC informed physicians and their families and urged their involvement locally to help elect those candidates who have supported or have indicated they're willing to support and protect quality health care," said IMPAC Chairman Jere Freidheim, MD.

Illinois House Republicans lost six key races Nov. 5, giving Democrats the edge with a 60-58 majority. When the Illinois General Assembly convenes in January 1997, House Democratic Leader Michael Madigan will likely return to the speaker's position he held for 12 years before Republicans wrested control of the Illinois House from Democrats in 1994. In 1995, the Republican majority in the House helped pass H.B. 20, a comprehensive tort reform law that ISMS spent 20 years working to achieve.

In two races of special interest, physicians' spouses defeated their opponents to win a two-year term in the Illinois House. State Rep. Gwenn Klingler (R-Springfield), the wife of a dermatologist, will return for her second term after defeating her challenger, Mary Lou Lowder
(Continued on page 15)

Women in managed care have direct access to obstetricians, gynecologists

CHANGE: Patients need information to understand new state law. BY JANE ZENTMYER

[CHICAGO] A law that became effective Nov. 14 allows women to have direct access – without referrals or prior approval from insurance plans – to any physician who specializes in obstetrics or gynecology and who participates in the women's managed care plans. This measure – S.B. 1246, which was signed by Gov. Jim Edgar on July 17 – was somewhat overshadowed by H.B. 2557, the measure that requires insurers to pay for at least 48 hours of inpatient care for mothers and newborns following a vaginal delivery and 96 hours following a cesarean section. But the guarantee of direct access makes it easier for women to get care from the physicians whom they see the most.

"Surveys show that women are more likely to have been examined by their obstetrician or gynecologist within the last two years than by any other
(Continued on page 15)

Highlights of new law

Effective Nov. 14, the new law

✓ Defines a "woman's principal health care provider" as a "physician licensed to practice medicine in all of its branches specializing in obstetrics or gynecology."

✓ Requires plans to allow women to choose a principal health care provider.

✓ Requires plans to permit women to select either one physician as both their principal health care provider and their primary care physician, or to select two different physicians, with one being a principal health care provider and the other their primary care provider.

✓ Allows women to see their principal health care provider directly for services covered by the plan or policy, with no referral or restriction.

✓ Doesn't mandate coverage of all obstetric and gynecologic services.

✓ Applies to patients covered by individual or group policies for accident and health insurance or managed care plans as long as those policies were amended or renewed after effective date. Also covered are Medicaid recipients; employees of county, municipality and state government and other government bodies; and individuals insured by companies normally exempt under ERISA.

Illinois Medical PSO stock offering closes

SETBACK: Board explores other opportunities to bring services to physicians. BY JANE ZENTMYER

[CHICAGO] The Board of Directors of the Illinois Medical Physician Services Organization voted to close the company's stock offering as of Oct. 23 because the funds invested during the three-month offering period failed to meet the company's capitalization goal. The Board decided its next step is exploring other options to offer physicians the services they need in a managed care marketplace, according to Edward Fesco, MD, chairman of the Illinois Medical PSO Board.

"Almost all the doctors who

were contacted realized the potential of [the PSO]," Dr. Fesco said. "They were not necessarily willing to invest in it. They were hoping it would somehow fly without their assistance at this time." The PSO's business plan and its intellectual property, however, are still intact, he noted. "The PSO Board is exploring the possibilities and evaluating future deployment of the PSO and will certainly notify membership of the success of its efforts."

"Our members failed to
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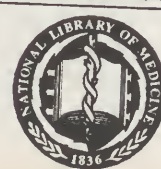
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Illinois Supreme Court will review Berlin decision

PHYSICIAN EMPLOYMENT: Corporate practice of medicine issue continues. BY DEBORAH PREISER

[SPRINGFIELD] The Illinois Supreme Court has agreed to review the Fourth District Appellate Court's ruling in April invalidating a physician employment contract on the grounds that it violated the statutory prohibition of the corporate practice of medicine.

In *Berlin vs. Sarah Bush Lincoln Health Center*, the appellate court upheld the Coles County trial court decision that the employment contract between Richard Berlin, MD, and the Charleston health center was unenforceable because the health center is licensed as a not-for-profit corporation and cannot engage in medical practice. Such practice, the lower court noted, violates the state Medical Practice Act, which says only individuals licensed to practice medicine may do so.

"Since the Supreme Court takes very few cases, just 5 to 10 percent of those presented, the court is saying that this is a significant case," said ISMS General Counsel Saul Morse. "Another indication that the courts view this as an important case is the fact that all three judges on the appellate court panel wrote an opinion. That's pretty rare."

The appellate court's decision was in line with ISMS House of Delegates policy and with the amicus curiae brief that ISMS, along with several county medical

societies and the AMA, filed in support of Dr. Berlin, according to Morse. By the end of November, ISMS will file an amicus brief in support of Dr. Berlin with the Supreme Court. Oral arguments will probably begin next spring, Morse said.

"Frankly, no matter what the Supreme Court rules, I fully expect to see

legislation introduced before long to change the current law," Morse said. "One side is likely to argue that physicians should have more autonomy and freedom – and make it impossible for them to become employees of any corporation. Others will want legislation that will allow corporations to hire doctors and control health care, all under the guise of saving money."

Dr. Berlin resigned from the health center in 1994 to work at the Carle Clinic Association's Mattoon-Charleston branch, one mile from Sarah Bush Lin-

coln. He had signed an employment contract with Sarah Bush Lincoln in 1992 that prohibited him from affiliating with "any person, firm or corporation engaged in competition with [the] hospital in providing health care services within a 50-mile radius" during the term of the agreement and for two years afterward.

Sarah Bush Lincoln filed suit to enjoin Dr. Berlin from practicing at Carle. He ultimately left Carle and set up private practice but sued the hospital, seeking a declaratory judgment that the contract's restrictive covenant was unenforceable. ■

AMA honors Porter as advocate of medicine

AWARD: Legislator's support of biomedical research is recognized.

BY DEBORAH PREISER

[WASHINGTON] For promoting the interests of medicine, especially biomedical research, U.S. Rep. John Porter (R-10th) of Illinois received a prestigious 1996 Dr. Nathan Davis Award from the American Medical Association on Nov. 20 in Washington, D.C. Porter was nominated by ISMS and other medical groups.

"I am deeply honored to receive this recognition for my work in support of biomedical research. Investment in this area pays enormous dividends to our society," Porter told *Illinois Medicine*. "I am committed to supporting the National Institutes of Health and this endeavor."

Named for the founder of the AMA, the awards recognize individuals

throughout all levels of government, from U.S. senators and representatives to public servants at state and local levels, who make outstanding contributions "to promote the art and science of medicine and the betterment of the public health."

In nominating Porter, M. LeRoy Sprang, MD, chairman of the ISMS Board of Trustees, wrote: "Rep. Porter has always been a champion of medicine and a true patient advocate." Dr. Sprang noted that ISMS has been working with Porter since 1973 when Porter was first elected to the Illinois General Assembly. Porter will be serving his 10th term in the U.S. House of Representatives.

Porter "has worked tirelessly during

his many years of service on the U.S. House Appropriations Committee and, more recently, as chairman of its Labor, Health and Human Services and Education Subcommittee, to prevent deep budget cuts impacting biomedical research," wrote Dr. Sprang. "More important, the congressman actually increased funding for the National Institutes of Health."

For fiscal year 1996, Porter single-handedly lobbied the U.S. House and Senate to increase NIH funding by 5.7 percent despite budget cuts demanded by his colleagues, said Dr. Sprang. "During the FY '97 debate, the congressman fiercely fought for a 6.9 percent increase in funding. Not only did Rep. Porter win this fight, he also secured the endorsement of a funding plan to make it easier for NIH to rebuild its aging clinical center without cutting back on NIH's budget for research and grants – all this while meeting federal budget reduction targets." ■

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Panel reports on drug advances in treatment of schizophrenia

PROGRESS: Use of atypical APDs increases efficacy and decreases side effects. BY KAREN TITUS

[CHICAGO] A new generation of antipsychotic drugs, the so-called atypical APDs, has placed the treatment of schizophrenia at the threshold of more effective treatment with fewer side effects, according to a panel discussion at a meeting held by the American Psychiatric Association's Institute on Psychiatric Services from Oct. 18 to 22 in Chicago. "Raising the standard of care is no longer just a hypothesis, nor a legal or managed care term. It is now within our reach," said Jeffrey Lieberman, MD.

The atypical APDs are characterized by clinical criteria ranging from superior efficacy – including effectiveness against the negative symptoms of schizophrenia – to fewer side effects related to elevated prolactin levels, according to Dr. Lieberman, vice chairman of the Department of Psychiatry at the University of North Carolina at Chapel Hill School of Medicine.

The exact mechanisms of the drugs, however, are not fully understood. "Why are these atypical drugs?" asked Dr. Lieberman. One theory is that these are "smart" drugs that target only those areas of the brain in which the pathology of the disease is located, he said. A second hypothesis is that the atypicals act in multiple neurotransmitter systems involving epinephrine, serotonin and other substances in addition to dopamine. A third theory is that the atypical APDs act not only on the dopamine 2 receptor but on other dopamine receptor subtypes. The most successful atypical compounds appear to be those that block not only dopamine 2 receptors but other neurotransmitter receptors simultaneously, reported Dr. Lieberman.

Regardless of how they work, their net effect is a markedly separated dose-response curve, providing a wider separation between efficacy and side effects than exists with conventional drugs, Dr. Lieberman said.

SUCCESSFUL LONG-TERM treatment of schizophrenia also hinges on aggressive, systematic psychopharmacologic treatment at the time of the first episode, noted panelist Diana Perkins, MD, director of the Schizophrenia Treatment and Evaluation Program at UNC Hospitals and UNC School of Medicine.

Treatment should be with the lowest possible doses of atypical ADPs, especially at the time of the first episode, when patients are more sensitive to neuroleptic side effects, Dr. Perkins said.

"The '70s and '80s were a time when things were big – big hair, big shoes, big drugs," she said. "Lots and lots of haloperidol was considered good. Now we know better – you don't want to overshoot your therapeutic window."

Reduced side effects may increase

long-term patient compliance, she added, noting that most patients diagnosed with schizophrenia must remain on antipsychotic medications the rest of their lives.

Acknowledging that patients and third-party payers may balk at the expense of the atypical APDs, Dr. Perkins pointed out that the cost of relapses may be as high or higher.

Also critical to successful treatment is psychotherapy. "It gives you an extra edge in developing a therapeutic alliance with patients," Dr. Perkins said. Physicians can also use therapy to help patients process the trauma of hospitalization and to educate patients about the

nature of their newly diagnosed illness, she added.

In the long term, the new medications may bring the treatment of schizophrenia to the current treatment level of diabetes, said panelist Joseph McEvoy, MD, deputy clinical director of the John Umstead Hospital in Chapel Hill. "With diabetes, we used to focus on late-end stages of the disease, such as gangrene and blindness. Now we're seeing that if we focus on tight blood sugar control, we can eliminate many of those problems. Hopefully, the new atypicals will allow us to reach that same level of success in treating schizophrenia." ■



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REPORT for Illinois Physicians

MANAGED CARE REPORT CARDS

Over the past several years, several versions of HEDIS (*the Health Plan Employer Data and Information Set*) have been released. Many managed care plans, including HMO Illinois and MCNP/BlueChoice, have been measuring and reporting HEDIS data.

The HEDIS data set includes measures of preventive care (such as childhood immunization rates, mammography screening rates, cervical cancer screening rates), measures of care provided to members of the plan (asthma inpatient rates, percentage of women who have begun prenatal care in the first trimester, low birth-weight rate), measures of member access and satisfaction, and administrative and financial information about the plan.

From the health plan perspective, there are several benefits to collecting HEDIS data. Results that do not meet established goals stimulate evaluation of potential underlying causes and can lead to valuable quality improvement activities. Collection and review of data has helped health plans to better understand certain aspects of care being provided, and allows a plan to monitor changes within its population over time.

However, there are significant limitations to HEDIS data. While the number of HEDIS measures has increased over the past several years, HEDIS still monitors only limited aspects of the health care process. It is frequently used to compare one health plan to another, although the health plans may differ markedly in members' age and socioeconomic status, benefits covered by the health plan, or initial health status of members prior to enrollment in the plan. HEDIS makes no adjustments for these factors, so it is more useful for following trends within a plan than for comparing plans to one another.

The data is collected by health plans, and is not subject to independent audits.

A strength of HEDIS lies in its clear definitions for each measure. These definitions involve defining inclusion and exclusion criteria for the denominator of a measure (how long must a member have been enrolled in the plan to evaluate the plan's care? How do you decide, for HEDIS purposes, whether or not a member is a diabetic?) and criteria for determining who belongs in the numerator (what documentation must be present to conclude that a procedure was done? Is a reference in a progress note good enough or must the report be present?) This strength leads to problems, as well, as the stringent criteria to determine that a procedure was in fact done will in some instances result in under measurement. This is another potential area for misinterpretation when plan results are evaluated internally or in comparison to other plans.

Detailed information about HEDIS is available on the Internet from the National Committee for Quality Assurance (www.ncqa.org). That site also contains information about the Quality Compass, which reports HEDIS results for some health plans.

Blue Cross and Blue Shield is committed to working with the National Committee for Quality Assurance (NCQA), sponsor of HEDIS, because Illinois employers are committed to the process and require our participation. We believe that good can come out of it, and take pride when you, (through our network), meet or exceed NCQA standards. We commit to maintaining vigilance so that reporting requirements and data remain meaningful and clinically relevant.

(Issue: 11/22/96 - AMK)

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EDITORIAL

A threshold in cancer research

We're approaching the 25th anniversary of the National Cancer Act, which recognized the need for an interdisciplinary approach to cancer treatment, research and education. At the signing of the act on Dec. 23, 1976, President Richard Nixon said: "Each year [cancer] takes more lives in this country alone than we lost in battle in all of World War II. But just as cancer represents a grim threat to men and women and children in all parts of the world, so the launching of our great crusade against cancer should be a cause for new hope among people everywhere."

In many ways, the results of that crusade have matched the hope placed in it. In an interview in the Chicago Tribune, Richard Klausner, MD, director of the National Cancer Institute, characterized our progress: "What the 25-year investigation into cancer has brought us is to look at the cancer cell in totally new ways, to identify the molecular fingerprint that tells us what the difference is between cancers, that this one will respond to this treatment, and that one won't. We're now on the verge of being able to do this, and this is an amazing victory."

The American Cancer Society quantified our progress during the last 60 years: In the 1930s, fewer than one in five cancer patients was alive five years after treatment. In the 1940s, it was one in four, and in the 1960s, it was one in

three. About 544,000 Americans, or four of 10 patients who get cancer this year, will be alive five years after diagnosis. The gain from the 1960s to the present represents more than 91,000 people per year.

Unfortunately, there has also been a steady rise in the cancer mortality rate in the United States in the past half-century, according to the ACS. The age-adjusted rate in 1930 was 143 per 100,000 population. It rose to 157 in 1950, to 163 in 1970 and to 172 in 1992. This increase has mainly been caused by lung cancer. Excluding lung cancer deaths, cancer mortality declined 15 percent between 1950 and 1991.

The National Cancer Institute reports that in 1996, 10 million of our patients and peers have a history of cancer and owe their lives to cancer research that has significantly improved prevention, diagnosis and treatment. Despite the recent research fraud that caused the National Center for Human Genome Research to retract five published articles on acute myelogenous leukemia, we have made tremendous progress in genetic research. In fact, a company announced late last month that it would sell for \$2,400 the most comprehensive genetic test yet to predict breast cancer.

It will be interesting to see how our handling of lifestyle issues like smoking, as well as the ethical and social implications of genetic research, will affect our progress over the next 25 years.

PRESIDENT'S LETTER

Giving thanks

Sandra F. Olson, MD



We have an intangible sense of heritage that inspires us to share our material benefits.

Thanksgiving is a unique American holiday with boundless appeal for all people who call this country home. In 1863, when President Abraham Lincoln proclaimed the fourth Thursday in November as a day set aside to pause and thank our Creator for our benefits, he probably didn't realize what an important and enduring legacy he was establishing. The holiday captures not just the remembrance of those early pilgrim ancestors and the courage that brought them here, nor the benevolent welcome of the Wampanoag Indians who helped them survive, but the spirit of gratitude for being an American.

The American Indians who greeted these strange and different people and accepted them at face value started a tradition upon which this country was founded and through which our nation has flourished to become the greatest on earth. For that we must be ever grateful. And what a fitting and tangible way the pilgrims chose to express their gratitude – a shared meal, a communion, the universal union of friendship and good will.

Through the yearly remembrance of this event, we have an intangible sense of heritage that inspires us to share our material benefits with others who are less fortunate. Witness the food and clothing drives that are sponsored by organizations during this season. Our community spirit seems to surge with these activities. People are more generous and willing to help others around this time.

When we think of Thanksgiving, we tend to think of traditional food on the menu – the turkey, stuffing, cranberries and pumpkin pie – as pictured in the famous Norman Rockwell painting. For many, this meal is a real occasion for celebration and for sharing, fellowship and family. At our house, it's a joint effort. My brother Bob usually brings the turkey and cranberries; my sister fixes the vegetables; friends Carol and Bernie bring hors

d'oeuvres and candy, respectively. My speciality is the dessert. And as we sit down, we always say grace to thank God, family and friends for their gifts, with a little impromptu editorializing on our current situations. I suspect our day is pretty typical of that of many Americans.

The sense of history and community, as well as a universal and nondenominational spirituality, is the overriding theme and causes this holiday to transcend other holidays. Thanksgiving is not the property of any one religion, heritage or ethnic group, nor does it celebrate a particular person's achievements. And therein lies its universal appeal. No one should feel left out or uncomfortable. It's truly a holiday for which "one size fits all." All ages, religions and cultures are welcome. Even if people are not citizens, they can enjoy friendship, a good meal and the Detroit Lions on TV.

Thanksgiving also reminds us of our communal spirit and shared societal values. Thomas Merton's phrase "No man is an island" reflects our sentiment well on this occasion. As physicians, we certainly understand that concept. How could we exist without our patients, colleagues, staff and family?

Which brings me to my closing thought. I have much to be thankful for as your president. My family supports me in more ways than I can say; without them, I could not attempt the various assignments and duties I have. The staff at ISMS are invaluable for what they do to keep me on the road as your president. My secretary, Wanda, has provided that extra effort when it comes to changing appointments, tracking me down, handling extra messages, etc. Even my patients have not grumbled when appointments have been changed at a few days' notice. But most of all, I am indebted to you, the members, for your loyalty, friendship and good will in asking me to be your president. To all of you, I give thanks.

LETTERS

It's the war on drugs, stupid!

I take exception to the tone of your editorial on attention deficit disorder and the use of Ritalin (Sept. 13 issue), which seems merely to mimic the country's hysteria about substances that have the capacity for mind-altering effects.

You referred to a psychiatrist who was said to fear that a diagnosis of adult ADD was becoming an excuse for any sort of psychological problem. That person has not been in the trenches and has not seen the appearance of attention deficit disorder lurking behind such conditions as major depression, schizophrenic and obsessive-compulsive disorders, and essentially any other major Axis I or Axis II diagnosis, including substance abuse.

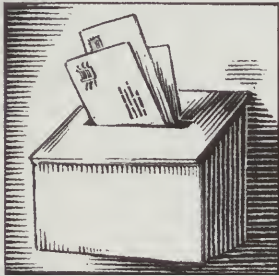
I have had occasion to review records of people who have been in

the mental health system for some years and then recently were clearly diagnosable with ADD. Schizophrenia, character disorders and substance abuse make a major appearance in their records. If there's any cause for alarm, it is the reluctance of physicians to consider the possibility of adult ADD even in the presence of other diagnoses.

The fact that there has been a 500 percent increase in Ritalin use could perhaps be applauded as finally representing a recognition of the severity and prevalence of this disorder. Allegations of apparent misuse of Ritalin are part of the alarmist and hysterical attempt to find possible substance abuse difficulties as part of the continuing "war on drugs" that is seizing this country.

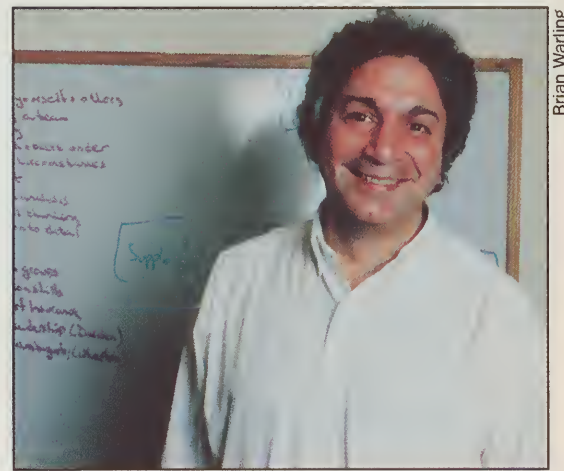
— Richard L. Grant, MD
Peoria

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"How dare you tell me that I have a 'common' cold!"

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State Democrats
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ISMIE Update

Seminar describes ISMIE defense procedures for policyholders

LAWSUITS: Physicians have a support system. BY DEBORAH PREISER

[OAK BROOK] "Malpractice lawsuits are an inescapable reality of today's environment," said James Ahstrom, MD, at the ISMIE-sponsored seminar "Taking Control: Managing Your Malpractice Lawsuit," held Oct. 16 in Oak Brook. "One out of every five doctors in the United States is sued every year," he told physicians and their spouses. "Being on the receiving end of a lawsuit certainly doesn't mean a doctor is incompetent or careless."

"The primary philosophy of the Illinois State Medical Inter-Insurance Exchange is to try to defend every physician," continued Dr. Ahstrom, chairman of ISMIE's Litigation Support Network. "We are successful more than 80 percent of the time." ISMIE figures show that about 17 percent of cases settle in favor of the plaintiff and only 5 percent go to trial.

Physicians named in lawsuits

are an important part of the defense team, according to Kevin Glenn, an attorney with the Chicago firm Bresler, Harvick and Glenn Ltd. "Soon after a physician-defendant notifies ISMIE of a lawsuit, there's a meeting with the doctor, an ISMIE professional claims analyst and the defense attorney assigned to the case. We start building the defense. The doctor needs to teach us the medical issues involved. It's helpful to bring any related records, any notes written by the doctor during review of the records and any literature that supports the actions of the doctor in treating the patient."

As a result of state tort reform enacted in the '80s, before filing a lawsuit, the plaintiff attorney must request a copy of the patient's records for review by an outside physician who determines whether the case has merit. So, any changes

the physician-defendant makes on the record after that review process creates a record that does not match the one the plaintiff attorney has in hand.

Especially because of the potential for creating two records, physicians should never change medical records if a lawsuit has been filed or they have reason to think it might be, Glenn said. "We cannot defend changed records. If you remember other things related to how you handled the case, make notes to yourself on a separate sheet of paper as you review the records."

Although it's tempting to do otherwise, physicians who have been sued should not talk with anyone about the case except those few people who are privileged — the physician's lawyer, spouse and an ISMIE claims analyst, Glenn said. Others can become witnesses against the physician if the doctor has talked

ISMIE Annual Meeting set for April 16

Nominations sought for board membership.

The Illinois State Medical Inter-Insurance Exchange will hold its Annual Meeting on Wednesday, April 16, 1997, at the Oak Brook Hills Resort in Oak Brook. At that time, elections will be held for the ISMIE Board of Governors. Board members are elected by a majority vote of those members who are represented at the Annual Meeting in person or by proxy.

The Board of Governors has general supervision over ISMIE's finances and operations and establishes all policies governing the proper transaction and conduct of ISMIE business and affairs.

Any ISMIE policyholder interested in serving as a governor should so notify by providing a 150-word statement of interest and a current curriculum vitae to Harold Jensen, MD, Chairman, Board of Governors, Illinois State Medical Inter-Insurance Exchange, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. Each candidacy must be seconded in writing by two other ISMIE policyholders. A member of ISMIE may second nominations for up to seven separate and individual Board candidates. All statements, CVs and written seconds must be received at the ISMIE office on or before Dec. 31, 1996.

All candidate submissions will be reviewed by ISMIE's Nominating Committee, which will then provide a recommended slate of nominees. Candidates not being recommended by the Nominating Committee will be so advised and may elect to be placed on the ballot as independent candidates.

Chicago-based company is latest ISMIE-approved broker

EXPANSION: Near North Insurance Brokerage Inc. continues tradition of varied products and services. BY JANE ZENTMYER

[CHICAGO] The Chicago-based Near North Insurance Brokerage Inc. has been added to the list of ISMIE-approved brokerages authorized to represent ISMIE and sell its products, according to Harold Jensen, MD, chairman of the ISMIE Board of Governors. By working with brokerages like Near North, ISMIE is able to reach group practice administrators and other nonphysicians who make insurance-buying decisions in a managed care environment, Dr. Jensen said.

Founded in 1962, Near North Insurance Brokerage Inc. is the 17th-largest broker in the brokerage industry and one of the largest privately held brokerages in the country, according to company information. Its Near North

Healthcare Practice division serves health care providers across the nation. The company markets medical professional liability services and programs, including risk management, for physician groups, managed care facilities, hospitals, long-term and residential care facilities, home health agencies and ambulatory care providers.

Near North Healthcare Practice represents more than 10,000 physicians nationally.

"Our philosophy is not merely to assign the insurance coverage and walk away from the process," said Sheila Kelly, senior vice president. "We add value with regard to risk management, quality assurance and loss prevention in claims management."

Others leading Near North include Eileen Oswald, senior vice president of health care risk management; Linda Miliken, Pat Muller and Mike Callahan, all vice presidents; and Mary Jo Cooney, assistant vice president.

"We recognize the significant role [ISMIE plays] in the Illinois physician marketplace and have a tremendous respect for how they have served the physicians," Kelly said.

Near North Insurance Brokerage Inc. expands the list of ISMIE-approved brokers, which includes Aon, Classic Insurance Services Ltd., Diederich Insurance, Medical Arts Insurance Affiliates Ltd., Medical Group Insurance Services and McLaughlin & Sons Inc.

with them about case issues.

"This is especially true if other doctors are involved in the case," Glenn explained. "Your first reaction is to talk with them about it. That's not a good idea. You do not want the jury to think the doctors got together to go over the details of the case. If you see the other doctors involved in the lawsuit, keep your conversations very general. Do not ask how they are going to testify."

Glenn's advice for physicians during the trial was simple: "The hardest witness to cross-examine is a truthful defendant. From interviews with jurors, we have found that the public still has a high regard for doctors."

To encourage physician-defendants' active participation, ISMIE provides the Defendant Reimbursement Program for active policyholders. Physicians get \$500 per day to attend depositions other than their own and the trial. "If jurors sense the doctor does not care about the case, they use that against us and punish us," Glenn said. "If you have been present at the other depositions, you know our plan. You will have helped prepare your lawyer and yourself."

Attendance is time-consuming but case-strengthening, said Glenn. "You have knowledge that we might want to tap into. Your lawyer may not realize that the other side's expert is giving gobbledygook for answers. If you're there, you're going to be helpful."

Being a defendant in a malpractice suit is stressful for physician families, Dr. Ahstrom said. Stress can be alleviated through the ISMIE Litigation Support Network, a group of physicians and their spouses who have gone through litigation. These volunteers listen to and understand physician-defendants and their families who are enduring a difficult experience. "By learning how the litigation process works and knowing there are others who have gone through it, physicians can view their situation more optimistically," Dr. Ahstrom said.

One physician attended the seminar because "I'm getting closer to giving my deposition, and I felt I needed help understanding the process and how lawyers think. It was comforting to hear the encouraging statistics [about the number of cases ISMIE has successfully defended]."

ISMS symposium urges physicians to **take charge**

With the right tools, physicians can gain leverage.

BY JANE ZENTMYER



Carlton Pearce, MD



Kristine E. Peterson



Jeff Goldsmith, PhD

Photos: John McNulty

Like many of his peers, Carlton Pearce, MD, helped found a physician-led managed care entity out of necessity: "We felt we had no contracting leverage. We really felt that if we could get together, we could at least get the payers to talk to us." Today, he is president of Generations Health Care Inc., a St. Louis-based, physician-owned organization formed by 29 Ob/Gyns in 1995.

Dr. Pearce recounted his experiences and the keys to his success at the ISMS-sponsored symposium "The Fundamentals of Physician Leadership" held Nov. 2 at the Marriott Oak Brook Hotel. The second annual symposium featured physicians like Dr. Pearce who described their own experiences in developing successful physician-driven organizations.

The start-up of Generations Health Care was challenging, according to Dr. Pearce. But each physician committed at least a \$5,000 initial investment followed by a contribution of \$45,000 in total assets so that the entity could become a corporation. Each doctor also agreed to remain for two years or lose his or her assets. With the company ending its second year in February 1997, it has worked to resolve problems with staffing, insufficient financial data, high administrative expenses and low morale. Dr. Pearce also cited such successes as a 33 percent savings on medical malpractice insurance rates, the avoidance of debt and the creation of a centralized computer network.

The corporation plans to cut costs, add more physicians, evaluate potential partnerships and work with payers for contracts, he explained. "We're trying to maintain a physician focus, which should be on health care delivery. If we lose that focus, we've lost everything. We need to try to keep our physicians focused on managing the patients. In a consumer-driven future, we'd better be doing a good job of taking care of patients."

That physician emphasis was addressed by M. LeRoy Sprang, MD, chairman of the ISMS Board of Trustees: "The truth is that only physicians have the education, the experience, the expertise to provide quality, cost-effective health care. Nobody else can do it but us."

Physicians should begin to look for opportunities to regain control of their professional lives as managed care matures, said Jeff Goldsmith, PhD, president of Health Futures Inc. and a lecturer in the department of medicine at the University of Chicago's Pritzker School of Medicine. Physician networks will help physicians maximize their leverage and ensure an appropriate balance of power.

"What the customer appears to want is not a provider prepackaged menu of doctors and hospitals but broad, disciplined, open panels with good geographic coverage and maximum flexibility," Goldsmith said. The intense trend toward inclusive, open panels has caused traditionally closed systems — such as Kaiser and Group Health Cooperative — to take the previously unthinkable step of establishing relationships with physicians in private practices. "There is scant evidence of economic advantage to the health plan, employer or consumer for selecting a closed panel system."

One implication of this trend is that physicians will see their leverage increase as managed care plans strive to broaden options for their enrollees, Goldsmith said. "The threat to exclude physicians from HMO panels because you do not grant deep enough discounts or accept brutally low [capitation] rates is increasingly hollow," said Goldsmith, who encouraged physicians not to sell their practices because it might not be the best long-term decision.

Those who have formed physician entities and retained control of their practices will have the most leverage as this trend toward open panels continues, he said. Physicians can protect their patients and strike a balance between economics and medical practice. "It is my belief that managed care still is young enough and fluid enough as a business that you can strategically reshape it and choose how you participate in it," Goldsmith told participants, adding that physicians "are going to have to learn to tolerate leadership."

Patients and physicians will get the tools to preserve quality care if the ISMS-developed Managed

(Continued on page 8)

PHYSICIANS attending the ISMS symposium in Oak Brook on Nov. 2 like what they're hearing about how doctors can lead managed care entities.



ISMS symposium

(Continued from page 7)

Care Patient Rights Act is approved by the Illinois General Assembly and signed by the governor, according to ISMS President Sandra Olson, MD. The complex bill was introduced during the spring 1996 legislative session, but legislators needed more time to analyze it. The measure is expected to be reintroduced in an upcoming session. In addition, new federal rules are making it easier for physicians to own and operate networks, said Norman Jeddelloh, a partner with the Chicago law firm Burditt & Radzius, Chartered.

Let's face it. Every doctor wants a job he or she can step right into, whether full-time or just filling in.

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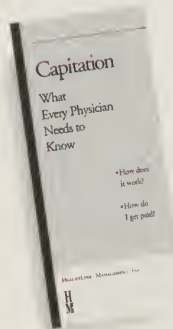
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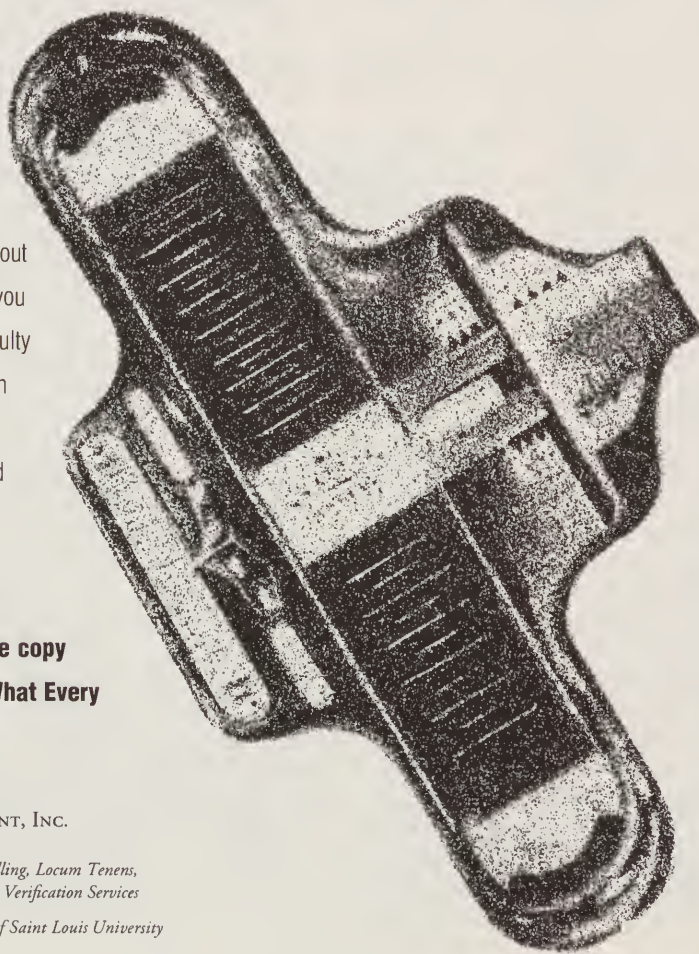
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Building patient loyalty can be tough, especially in a mobile society in which people move often and change health plans, said Kristine E. Peterson, president of K.E. Peterson Inc. in Chicago. "Be patient. As with everything we've seen in the past, it's just a pendulum that swings and swings and swings."

Physicians can take steps to encourage patients to stay with them, however. She advised physicians to watch for "moments of truth" or times when patients come into contact with some aspect of the practice and form a judgment based on their experiences. For example, word-of-mouth referrals from families, friends and associates may influence a patient's perspective. Someone calling to schedule an appointment may form opinions of the practice based on the number of times the telephone rings before someone answers, the receptionist's tone of voice and the length of time before the patient can see the physician. Physicians can't always control patient loyalty, but satisfied patients will be reluctant to switch physicians, she said.

Automating an office offers significant benefits to physicians despite a hefty initial investment, according to Frederic Renold, MD, MBA, who is responsible for computer and office automation for the Medical Care Group Ltd., a single-specialty group with five offices in the northwestern Chicago suburbs. Using on-line progress notes can save \$35 a day in physician and staff time; computer access to patients' test results can eliminate duplicative testing and save physicians about \$65 daily; and quicker access to patient records can save \$300 a day by eliminating the time spent searching for charts. More savings result from discontinuing photocopies and faxes, reducing the cost of filing and file retrieval, and cutting the time for processing prescription refills, he said.

Patients' health care choices are influenced by how much they know about their care, according to Wendy Lynch, PhD, of Lynch Consulting in Lakewood, Colo. Studies have shown that education about self-care reduced physician office visits by 17 percent, and education about emergency department use decreased emergency department visits by 11.6 percent, Lynch said.

Physicians can help patients become better-informed and select appropriate medical care, she said. "We are underestimating how much patients already are involved in decision-making about their own care," Lynch said. Physician involvement and support of patient choices increase patient satisfaction.

In a survey, almost 40 percent of respondents said physicians should counsel patients on home safety; 40 percent wanted information on social support; and almost 25 percent wanted physician counseling on financial problems, Lynch said. Nearly 50 percent said physicians should counsel patients about marital problems, if asked to do so. "We have high expectations of our physicians," she said.

Those high expectations are among the changes in health care, but physician leadership is the means to manage those changes. Howard Kirz, MD, chairman of the Clearwater Group in Los Gatos, Calif., said, "You cannot turn back the hands of time," adding that it is unlikely our country will support big increases in health care spending. "So the topic of today's conference is your answer. It's [all about] physician leadership." ■

This information is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

December 1995

Edward Riley, Chicago – physician and surgeon license placed on probation for one year due to alleged gross negligence for his failure to appear at a hospital to treat or diagnose a patient in a timely fashion.

Timothy J. Ryan, Waukegan – physician and surgeon license and controlled substance license reprimanded and fined \$5,000 after allegedly attempting to dispense and/or attempting to cause to be dispensed one prescription for Fastin (quantity 14, no refills) for himself.

Pravin S. Shah, Hanover Park – physician and surgeon license restored to probation.

Ched C. Vugrincic, South Elgin – physician and surgeon license suspended for two years with said suspension stayed after 180 days, followed by indefinite probation due to unprofessional conduct and gross overcharging for professional services.

January 1996

Marcos Que, Gibson City – physician and surgeon and controlled substance licenses revoked for prescribing and dispensing controlled substances for nontherapeutic purposes, failing to maintain controlled substances dispensing logs and failing to conduct controlled substance inventories.

February 1996

Kwabena Boateng, Joliet – physician and surgeon license reprimanded and fined \$1,400 after practicing on a non-renewed license.

Jorge Olmos Carranza, Chicago – physician and surgeon and controlled substance licenses placed on probation for two years for allegedly prescribing a controlled substance for a patient without sufficient controls to prevent diversion.

Mitchell Ghen, Hillsboro Beach, Fla. – physician and surgeon license reprimanded after receiving a letter of concern and \$2,500 fine in the state of Florida.

Robert Goff, Ribblemead, Va. – physician and surgeon license indefinitely suspended after failing to comply with a previously ordered probation.

David Hanson, Riverside – temporary physician and surgeon certificate reprimanded for allegedly engaging in the unauthorized practice of medicine outside the scope of his temporary certificate.

Laurence Heineman, Highland – physician and surgeon license reprimanded after furnishing false information on an application for a controlled substance registration.

Kwan Bo Jin, Normal – physician and surgeon and controlled substance licenses revoked for failure to account for Ritalin tablets he prescribed, and due to his prescribing, one patient became delusional and addicted to Ritalin.

Robert C. Lynch, Newport Beach, Calif. – physician and surgeon license indefinitely suspended after being disciplined in the state of California.

Leonard Newmark, St. Louis, Mo. – physician and surgeon license indefinitely suspended after being disciplined in the state of Missouri.

Vicente Hian Po, Flossmoor – physician and surgeon license suspended for one year after allegedly performing examinations of a female patient without a nursing department representative being present and alleged inappropriate physical contact with the patient during the examinations.

Marc Richman, Largo, Fla. – physician and surgeon license reprimanded after

receiving a letter of concern and \$2,000 fine in the state of Florida.

Charles H. Schikman, Skokie – physician and surgeon and controlled substance licenses placed on probation for two years after allegedly prescribing excessive amounts of controlled substances to a patient previously identified to him as a drug addict.

Vincent William Steward, Chicago – physician and surgeon license temporarily suspended pending proceedings before the Medical Disciplinary Board after allegedly knowingly and unlawfully pos-

sessing controlled substances while controlled substance license was under indefinite suspension and for aiding and abetting an individual not licensed to practice medicine by allowing the individual to order, receive, prescribe and sell for profit controlled substances with the use of respondent's name, medical office and physician and surgeon license.

Varsha Upadhyaya, Chicago – physician and surgeon license reprimanded and fined \$1,500 for allegedly failing to properly comply with a lawful request for information made by the department's medical coordinator.

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daily comfort

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Voltaren[®]-X[®]R
(diclofenac sodium) extended-release tablets

*Indicates member of ISMS Fifty Year Club

***Bonczkowski**

Charlotte Bonczkowski, MD, a family physician from Mt. Prospect, died Sept. 18 at the age of 82. Dr. Bonczkowski was a 1942 graduate of the Kansas City University of Physicians and Surgeons, Kansas City, Mo.

***Cooperman**

Norman Cooperman, MD, an Ob/Gyn from Chicago, died Oct. 3 at the age of 85. Dr. Cooperman was a 1938 graduate of the Rush Medical College, Chicago.

Cywinski

John Cywinski, MD, a pediatrician from Streamwood, died Sept. 27 at the age of 62. Dr. Cywinski was a 1961 graduate of the St. Louis University School of Medicine, St. Louis, Mo.

***Gross**

Jerome Gross, MD, a general surgeon from Chicago, died Sept. 20 at the age of 75. Dr. Gross was a 1944 graduate of the New York University School of Medicine, New York, NY.

Maltz

J.H. Maltz, MD, a psychiatrist from

Chicago, died Sept. 13 at the age of 76. Dr. Maltz was a 1948 graduate of the Chicago Medical School, Chicago.

Prasad

Enoch Prasad, MD, a general practitioner from Frankfort, died Sept. 19 at the age of 63. Dr. Prasad was a 1965 graduate of the Christian Medical College, Madras University, Veliore, Tamil Nadu, India.

Price

Arthur Price, MD, a psychiatrist from Hinsdale, died Sept. 3 at the age of 61. Dr. Price was a 1961 graduate of the Loyola University Stritch School of

Medicine, Maywood.


***Schweppe**

John Schweppe, MD, an endocrinologist from Winnetka, died Sept. 4 at the age of 79. Dr. Schweppe was a 1943 graduate of the Northwestern University Medical School, Chicago.

***Tauras**

Vytautas Tauras, MD, an occupational medicine specialist from Kildeer, died Sept. 7 at the age of 89. Dr. Tauras was a 1932 graduate of the Vytauta Didziojo University Medical Fakelteto, Kaunas, Lithuania.

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(diclofenac sodium) extended-release tablets



Voltaren efficacy in a single daily dose¹



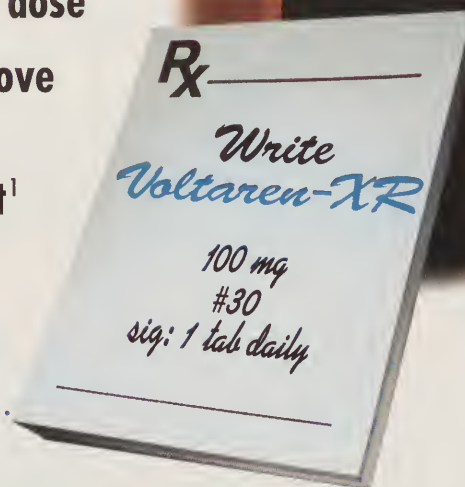
Once-daily convenience may improve patient compliance



Smallest once-a-day NSAID tablet¹



Actual tablet size



Contraindicated in patients hypersensitive to aspirin, other NSAIDs, or diclofenac.

As with other NSAIDs, the most frequent complaints relate to the GI tract. In patients treated chronically with NSAID therapy, serious GI toxicity such as bleeding, ulceration, and perforation can occur.

Elevations of AST and/or ALT, some significant, have been reported in association with diclofenac treatment; cases of severe hepatic reactions have been reported. If patients are treated chronically, periodic monitoring of transaminases is recommended. Please see brief summary of Prescribing Information on next pages.

Reference: 1. Data on file, Ciba.

For most OA and RA patients

Just once a day for a full day of relief

BlueCard Program expands to PPO members

[CHICAGO] Illinois members of the Blue Cross and Blue Shield Association’s PPO can now receive PPO benefits when they travel. The association’s expansion of its BlueCard Program to 32 million PPO members nationwide enables members to contact PPO providers if they need medical services away from home. BlueCard PPO members can now call an 800 number to get information on eligible BlueCard PPO providers. The BlueCard PPO includes 52 Blue Cross and Blue Shield Plan PPO networks in 42

states, including Illinois, as well as the District of Columbia and Puerto Rico. By Jan. 1, 1997, these provider networks will be available in most U.S. cities and towns. Illinois physicians who participate in the Blue Cross and Blue Shield Plan PPO can identify out-of-town BCBSA members by a “PPO in a suitcase” logo on their membership cards. A three-letter alphabetical prefix identifies the member’s independent Blue Cross and Blue Shield Plan. The provider can also verify membership and coverage by calling a toll-free number. ■

PAULA LUCARE AND SON
Alex Lucare share a happy moment as part of a Child Watch program, a field trip for lawmakers and corporate executives to show them firsthand the importance of childhood preventive health care services. Participants visited the Springfield Aid for Retarded Citizens facility in Springfield on Oct. 2.



Ron Ackerman

Cataflam®
diclofenac potassium
Immediate-Release Tablets

Voltaren®
diclofenac sodium
Delayed-Release (enteric-coated) Tablets

Voltaren®-XR
diclofenac sodium
Extended-Release Tablets

Brief Summary
(For Full Prescribing Information, see Package Insert.)

INDICATIONS AND USAGE
Cataflam Immediate-Release Tablets and Voltaren Delayed-Release Tablets are indicated for the acute and chronic treatment of signs and symptoms of osteoarthritis and rheumatoid arthritis. Voltaren-XR Extended-Release Tablets are indicated for chronic therapy of osteoarthritis and rheumatoid arthritis. In addition, Cataflam Immediate-Release Tablets and Voltaren Delayed-Release Tablets are indicated for the treatment of ankylosing spondylitis. Only Cataflam is indicated for the management of pain and primary dysmenorrhea, when prompt pain relief is desired, because it is formulated to provide earlier plasma concentrations of diclofenac (see CLINICAL PHARMACOLOGY, Pharmacokinetics and Clinical Studies).

CONTRAINDICATIONS
Diclofenac in all formulations, Cataflam, Voltaren, and Voltaren-XR, is contraindicated in patients with known hypersensitivity to diclofenac and diclofenac-containing products. Diclofenac should not be given to patients who have experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactic-like reactions to diclofenac have been reported in such patients (see WARNINGS—Anaphylactoid Reactions, and PRECAUTIONS—Preexisting Asthma).

WARNINGS
Gastrointestinal Effects
Peptic ulceration and gastrointestinal bleeding have been reported in patients receiving diclofenac. Physicians and patients should therefore remain alert for ulceration and bleeding in patients treated chronically with diclofenac even in the absence of previous G.I. tract symptoms. It is recommended that patients be maintained on the lowest dose of diclofenac possible, consistent with achieving a satisfactory therapeutic response.

Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy: Serious gastrointestinal toxicity such as bleeding, ulceration, and perforation can occur at any time, with or without warning symptoms, in patients treated chronically with NSAID therapy. Although minor upper gastrointestinal problems, such as dyspepsia, are common, usually developing early in therapy, physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous G.I. tract symptoms. In patients observed in clinical trials of several months to 2 years' duration, symptomatic upper G.I. ulcers, gross bleeding, or perforation appear to occur in approximately 1% of patients for 3-6 months, and in about 2%-4% of patients treated for 1 year. Physicians should inform patients about the signs and/or symptoms of serious G.I. toxicity and what steps to take if they occur.

Studies to date have not identified any subset of patients not at risk of developing peptic ulceration and bleeding. Except for a prior history of serious G.I. events and other risk factors known to be associated with peptic ulcer disease, such as alcoholism, smoking, etc., no risk factors (e.g., age, sex) have been associated with increased risk. Elderly or debilitated patients seem to tolerate ulceration or bleeding less well than other individuals, and most spontaneous reports of fatal G.I. events are in this population. Studies to date are inconclusive concerning the relative risk of various NSAIDs in causing such reactions. High doses of any NSAID probably carry a greater risk of these reactions, although controlled clinical trials showing this do not exist in most cases. In considering the use of relatively large doses (within the recommended dosage range), sufficient benefit should be anticipated to offset the potential increased risk of G.I. toxicity.

Hepatic Effects
Elevations of one or more liver tests may occur during diclofenac therapy. These laboratory abnormalities may progress, may remain unchanged, or may be transient with continued therapy. Borderline elevations (i.e., less than 3 times the ULN [=the Upper Limit of the Normal range]), or greater elevations of transaminases occurred in about 15% of diclofenac-treated patients. Of the hepatic enzymes, ALT (SGPT) is the one recommended for the monitoring of liver injury.

In clinical trials, meaningful elevations (i.e., more than 3 times the ULN) of AST (SGOT) (ALT was not measured in all studies) occurred in about 2% of approximately 5700 patients at some time during Voltaren treatment. In a large, open, controlled trial, meaningful elevations of ALT and/or AST occurred in about 4% of 3700 patients treated for 2-6 months, including marked elevations (i.e., more than 8 times the ULN) in about 1% of the 3700 patients. In that open-label study, a higher incidence of borderline (less than 3 times the ULN), moderate (3-8 times the ULN), and marked (>8 times the ULN) elevations of ALT or AST was observed in patients receiving diclofenac when compared to other NSAIDs. Transaminase elevations were seen more frequently in patients with osteoarthritis than in those with rheumatoid arthritis (see ADVERSE REACTIONS).

In addition to enzyme elevations seen in clinical trials, postmarketing surveillance has found rare cases of severe hepatic reactions, including liver necrosis, jaundice, and fulminant fatal hepatitis with and without jaundice. Some of these rare reported cases underwent liver transplantation.

Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac, because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. The optimum times for making the first and subsequent transaminase measurements are not known. In the largest U.S. trial (open-label) that involved 3700 patients monitored first at 8 weeks and 1200 patients monitored again at 24 weeks, almost all meaningful elevations in transaminases were detected before patients became symptomatic. In 42 of the 51 patients in all trials who developed marked transaminase elevations, abnormal tests occurred during the first 2 months of therapy with diclofenac. Postmarketing experience has shown severe hepatic reactions can occur at any time during treatment with diclofenac. Cases of drug-induced hepatotoxicity have been reported in the first month, and in some cases, the first two months of therapy. Based on these experiences, transaminases should be monitored within 4 to 8 weeks after initiating treatment with diclofenac (see PRECAUTIONS—Laboratory Tests). As with other NSAIDs, if abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), diclofenac should be discontinued immediately.

To minimize the possibility that hepatic injury will become severe between transaminase measurements, physicians should inform patients of the warning signs and symptoms of hepatotoxicity (e.g., nausea, fatigue, lethargy, pruritus, jaundice, right upper quadrant tenderness, and “flu-like” symptoms), and the appropriate action patients should take if these signs and symptoms appear.

Anaphylactoid Reactions
As with other NSAIDs, anaphylactoid reactions may occur in patients without prior exposure to diclofenac. Diclofenac should not be given to patients with the aspirin triad. The triad typically occurs in asthmatic patients who experience rhinitis with or without nasal polyps, or who exhibit severe, potentially fatal bronchospasm after taking aspirin or other nonsteroidal anti-inflammatory drugs. Fatal reactions have been reported in such patients (see CONTRAINDICATIONS, and PRECAUTIONS—Preexisting Asthma). Emergency help should be sought in cases where an anaphylactoid reaction occurs.

Advanced Renal Disease
In cases with advanced kidney disease, treatment with diclofenac, as with other NSAIDs, should only be initiated with close monitoring of the patient's kidney functions (see PRECAUTIONS—Renal Effects).

Pregnancy
In late pregnancy, diclofenac should, as with other NSAIDs, be avoided because it will cause premature closure of the ductus arteriosus (see PRECAUTIONS—Pregnancy, *Teratogenic Effects, Pregnancy Category B*, and Labor and Delivery).

PRECAUTIONS
General
Cataflam Immediate-Release Tablets, Voltaren Delayed-Release Tablets, and Voltaren-XR Extended-Release Tablets should not be used concomitantly with other diclofenac-containing products since they also circulate in plasma as the diclofenac anion.

Fluid Retention and Edema: Fluid retention and edema have been observed in some patients taking diclofenac. Therefore, as with other NSAIDs, diclofenac should be used with caution in patients with a history of cardiac decompensation, hypertension, or other conditions predisposing to fluid retention.

Hematologic Effects: Anemia is sometimes seen in patients receiving diclofenac or other NSAIDs. This may be due to fluid retention, G.I. blood loss, or an incompletely described effect upon erythropoiesis.

Renal Effects: As a class, NSAIDs have been associated with renal papillary necrosis and other abnormal renal pathology in long-term administration to animals. In oral diclofenac studies in animals, some evidence of renal toxicity was noted. Isolated incidents of papillary necrosis were observed in a few animals at high doses (20-120 mg/kg) in several baboon subacute studies. In patients treated with diclofenac, rare cases of interstitial nephritis and papillary necrosis have been reported (see ADVERSE REACTIONS).

A second form of renal toxicity, generally associated with NSAIDs, is seen in patients with conditions leading to a reduction in renal blood flow or blood volume, where renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients, administration of an NSAID results in a dose-dependent decrease in prostaglandin synthesis and, secondarily, in a reduction of renal blood flow, which may precipitate overt renal failure. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics, and the elderly. Discontinuation of NSAID therapy is typically followed by recovery to the pretreatment state.

Cases of significant renal failure in patients receiving diclofenac have been reported from marketing experience, but were not observed in over 4000 patients in clinical trials during which serum creatinine and BUN values were followed serially. There were only 11 patients (0.3%) whose serum creatinine and concurrent serum BUN values were greater than 2.0 mg/dL and 40 mg/dL, respectively, while on diclofenac (mean rise in the 11 patients: creatinine 2.3 mg/dL and BUN 28.4 mg/dL).

Since diclofenac metabolites are eliminated primarily by the kidneys, patients with significantly impaired renal function should be more closely monitored than subjects with normal renal function.

Porphyria: The use of diclofenac in patients with hepatic porphyria should be avoided. To date, 1 patient has been described in whom diclofenac probably triggered a clinical attack of porphyria. The postulated mechanism, demonstrated in rats, for causing such attacks by diclofenac, as well as some other NSAIDs, is through stimulation of the porphyrin precursor delta-aminolevulinic acid (ALA).

Aseptic Meningitis: As with other NSAIDs, aseptic meningitis with fever and coma has been observed on rare occasions in patients on diclofenac therapy. Although it is probably more likely to occur in patients with systemic lupus erythematosus and related connective tissue diseases, it has been reported in patients who do not have an underlying chronic disease. If signs or symptoms of meningitis develop in a patient on diclofenac, the possibility of its being related to diclofenac should be considered.

Preexisting Asthma: About 10% of patients with asthma may have aspirin-sensitive asthma. The use of aspirin in patients with aspirin-sensitive asthma has been associated with severe bronchospasm which can be fatal. Since cross-reactivity, including bronchospasm, between aspirin and other nonsteroidal anti-inflammatory drugs has been reported in such aspirin-sensitive patients, diclofenac should not be administered to patients with this form of aspirin sensitivity and should be used with caution in all patients with preexisting asthma.

Other Precautions: The pharmacologic activity of diclofenac may reduce fever and inflammation, thus diminishing their utility as diagnostic signs in detecting underlying conditions.

In order to avoid exacerbation of manifestations of adrenal insufficiency, patients who have been on prolonged corticosteroid treatment should have their therapy tapered slowly rather than discontinued abruptly when diclofenac is added to the treatment program.

Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If a patient develops such complaints while receiving diclofenac, the drug should be discontinued and the patient should have an ophthalmologic examination which includes central visual fields and color vision testing.

Information for Patients
Diclofenac, like other drugs of its class, is not free of side effects. The side effects of these drugs can cause discomfort and, rarely, more serious side effects, such as gastrointestinal bleeding, and more rarely, liver toxicity (see WARNINGS, Hepatic Effects), which may result in hospitalization and even fatal outcomes.

NSAIDs are often essential agents in the management of arthritis and have a major role in the management of pain, but they also may be commonly employed for conditions that are less serious.

Physicians may wish to discuss with their patients the potential risks (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS) and likely benefits of NSAID treatment, particularly when the drugs are used for less serious conditions where treatment without NSAIDs may represent an acceptable alternative to both the patient and physician.

Because serious G.I. tract ulceration and bleeding can occur without warning symptoms, physicians should follow chronically treated patients for the signs and symptoms of ulceration and bleeding and should inform them of the importance of this follow-up (see WARNINGS, Gastrointestinal Effects, *Risk of G.I. Ulcerations, Bleeding, and Perforation with NSAID Therapy*). If diclofenac is used chronically, patients should also be instructed to report any signs and symptoms that might be due to hepatotoxicity of diclofenac; these symptoms may become evident

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between visits when periodic liver laboratory tests are performed (see WARNINGS, Hepatic Effects, and PRECAUTIONS—Laboratory Tests).

Laboratory Tests

Hepatic Effects: Transaminases and other hepatic enzymes should be monitored in patients treated with NSAIDs. For patients on diclofenac therapy, it is recommended that a determination be made within 4 weeks of initiating therapy and at intervals thereafter. If clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g. eosinophilia, rash, etc.) and abnormal liver tests are detected, persist or worsen, diclofenac should be discontinued immediately.

Hematologic Effects: Patients on long-term treatment with NSAIDs, including diclofenac, should have their hemoglobin or hematocrit checked periodically for signs or symptoms of anemia. Appropriate measures should be taken in case such signs of anemia occur.

Drug Interactions

Aspirin: Concomitant administration of diclofenac and aspirin is not recommended because diclofenac is displaced from its binding sites during the concomitant administration of aspirin, resulting in lower plasma concentrations, peak plasma levels, and AUC values.

Anticoagulants: While studies have not shown diclofenac to interact with anticoagulants of the warfarin type, caution should be exercised, nonetheless, since interactions have been seen with other NSAIDs. Because prostaglandins play an important role in hemostasis, and NSAIDs affect platelet function as well, concurrent therapy with all NSAIDs, including diclofenac, and warfarin requires close monitoring of patients to be certain that no change in their anticoagulant dosage is required.

Digoxin, Methotrexate, Cyclosporine: Diclofenac, like other NSAIDs, may affect renal prostaglandins and increase the toxicity of certain drugs. Ingestion of diclofenac may increase serum concentrations of digoxin and methotrexate and increase cyclosporine’s nephrotoxicity. Patients who begin taking diclofenac or who increase their diclofenac dose or any other NSAID while taking digoxin, methotrexate, or cyclosporine may develop toxicity characteristics for these drugs. They should be observed closely, particularly if renal function is impaired. In the case of digoxin, serum levels should be monitored.

Lithium: Diclofenac decreases lithium renal clearance and increases lithium plasma levels. In patients taking diclofenac and lithium concomitantly, lithium toxicity may develop.

Oral Hypoglycemics: Diclofenac does not alter glucose metabolism in normal subjects nor does it alter the effects of oral hypoglycemic agents. There are rare reports, however, from marketing experiences, of changes in effects of insulin or oral hypoglycemic agents in the presence of diclofenac that necessitated changes in the doses of such agents. Both hypo- and hyperglycemic effects have been reported. A direct causal relationship has not been established, but physicians should consider the possibility that diclofenac may alter a diabetic patient’s response to insulin or oral hypoglycemic agents.

Diuretics: Diclofenac and other NSAIDs can inhibit the activity of diuretics. Concomitant treatment with potassium-sparing diuretics may be associated with increased serum potassium levels.

Dther Drugs: In small groups of patients (7-10/interaction study), the concomitant administration of azathioprine, gold, chloroquine, o-penicillamine, prednisolone, doxycycline, or digitoxin did not significantly affect the peak levels and AUC values of diclofenac. Phenobarbital toxicity has been reported to have occurred in a patient on chronic phenobarbital treatment following the initiation of diclofenac therapy.

Protein Binding

In vitro, diclofenac interferes minimally or not at all with the protein binding of salicylic acid (20% decrease in binding), tolbutamide, prednisolone (10% decrease in binding), or warfarin. Benzylpenicillin, ampicillin, oxacillin, chlortetracycline, doxycycline, cephalothin, erythromycin, and sulfamethoxazole have no influence *in vitro* on the protein binding of diclofenac in human serum.

Drug/Laboratory Test Interactions

Effect on Blood Coagulation: Diclofenac increases platelet aggregation time but does not affect bleeding time, plasma thrombin clotting time, plasma fibrinogen, or factors V and VII to XII. Statistically significant changes in prothrombin and partial thromboplastin times have been reported in normal volunteers. The mean changes were observed to be less than 1 second in both instances, however, and are unlikely to be clinically important. Diclofenac is a prostaglandin synthetase inhibitor, however, and all drugs that inhibit prostaglandin synthesis interfere with platelet function to some degree; therefore, patients who may be adversely affected by such an action should be carefully observed.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term carcinogenicity studies in rats given diclofenac sodium up to 2 mg/kg/day (or 12 mg/m²/day, approximately the human dose) have revealed no significant increases in tumor incidence. There was a slight increase in benign mammary fibroadenomas in mid-dose-treated (0.5 mg/kg/day or 3 mg/m²/day) female rats (high-dose females had excessive mortality), but the increase was not significant for this common rat tumor. A 2-year carcinogenicity study conducted in mice employing diclofenac sodium at doses up to 0.3 mg/kg/day (0.9 mg/m²/day) in males and 1 mg/kg/day (3 mg/m²/day) in females did not reveal any oncogenic potential. Diclofenac sodium did not show mutagenic activity in *in vitro* point mutation assays in mammalian (mouse lymphoma) and microbial (yeast, Ames) test systems and was nonmutagenic in several mammalian *in vitro* and *in vivo* tests, including dominant lethal and male germinal epithelial chromosomal studies in mice, and nucleus anomaly and chromosomal aberration studies in Chinese hamsters. Diclofenac sodium administered to male and female rats at 4 mg/kg/day (24 mg/m²/day) did not affect fertility.

Pregnancy, Teratogenic Effects, Pregnancy Category B

Reproduction studies have been performed in mice given diclofenac sodium (up to 20 mg/kg/day or 60 mg/m²/day) and in rats and rabbits given diclofenac sodium (up to 10 mg/kg/day or 60 mg/m²/day for rats, and 80 mg/m²/day for rabbits), and have revealed no evidence of teratogenicity despite the induction of maternal toxicity and fetal toxicity. In rats, maternally toxic doses were associated with dystocia, prolonged gestation, reduced fetal weights and growth, and reduced fetal survival. Diclofenac has been shown to cross the placental barrier in mice and rats. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should not be used during pregnancy unless the benefits to the mother justify the potential risk to the fetus. Because of the risk to the fetus resulting in premature closure of the ductus arteriosus, diclofenac should be avoided in late pregnancy.

Labor and Delivery

The effects of diclofenac on labor and delivery in pregnant women are unknown. Because of the known effects of prostaglandin-inhibiting drugs on the fetal cardiovascular system (closure of ductus arteriosus), use of diclofenac during late pregnancy should be avoided and, as with other nonsteroidal anti-inflammatory drugs, it is possible that diclofenac may inhibit uterine contractions and delay parturition.

Nursing Mothers

Because of the potential for serious adverse reactions in nursing infants from diclofenac, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Safety and effectiveness of diclofenac in pediatric patients have not been established.

Geriatric Use

Of the more than 6000 patients treated with diclofenac in U.S. trials, 31% were older than 65 years of age. No overall difference was observed between efficacy, adverse event, or pharmacokinetic profiles of older and younger patients. As with any NSAID, the elderly are likely to tolerate adverse reactions less well than younger patients.

ADVERSE REACTIONS

Adverse reaction information is derived from blinded, controlled, and open-label clinical trials, as well as worldwide marketing experience. In the description below, rates of more common events represent clinical study results; rarer events are derived principally from marketing experience and publications, and accurate rate estimates are generally not possible.

In 718 patients treated for shorter periods, i.e., 2 weeks or less, with Cataflam Immediate-Release Tablets, adverse reactions were reported one-half to one-tenth as frequently as by patients treated for longer periods. In a 6-month, double-blind trial comparing Cataflam Immediate-Release Tablets (N=196) versus Voltaren Delayed-Release Tablets (N=197) versus ibuprofen (N=197), adverse reactions were similar in nature and frequency. In controlled clinical trials, the incidence of adverse reactions for Voltaren Delayed-Release Tablets and Voltaren-XR Extended-Release Tablets at comparable doses were similar.

The incidence of common adverse reactions (greater than 1%) is based upon controlled clinical trials in 1543 patients treated up to 13 weeks with Voltaren Delayed-Release Tablets. By far the most common adverse effects were gastrointestinal symptoms, most of them minor, occurring in about 20%, and leading to discontinuation in about 3%, of patients. Peptic ulcer or G.I. bleeding occurred in clinical trials in 0.6% (95% confidence interval: 0.2% to 1%) of approximately 1800 patients during their first 3 months of diclofenac treatment and in 1.6% (95% confidence interval: 0.8% to 2.4%) of approximately 800 patients followed for 1 year.

Gastrointestinal symptoms were followed in frequency by central nervous system side effects such as headache (7%) and dizziness (3%).

Meaningful (exceeding 3 times the Upper Limit of Normal) elevations of ALT (SGPT) or AST (SGOT) occurred at an overall rate of approximately 2% during the first 2 months of Voltaren treatment. Unlike aspirin-related elevations, which occur more frequently in patients with rheumatoid arthritis, these elevations were more frequently observed in patients with osteoarthritis (2.6%) than in patients with rheumatoid arthritis (0.7%). Marked elevations (exceeding 8 times the ULN) were seen in 1% of patients treated for 2-6 months (see WARNINGS, Hepatic Effects).

The following adverse reactions were reported in patients treated with diclofenac:

Incidence Greater Than 1% - Causal Relationship Probable:

(All derived from clinical trials.)

*Incidence, 3% to 9% (incidence of unmarked reactions is 1%-3%).

Body as a Whole: Abdominal pain or cramps,* headache,* fluid retention, abdominal distention.

Digestive: Diarrhea,* indigestion,* nausea,* constipation,* flatulence, liver test abnormalities,*

PUB, i.e., peptic ulcer, with or without bleeding and/or perforation, or bleeding without ulcer (see above and also WARNINGS).

Nervous System: Dizziness.

Skin and Appendages: Rash, pruritus.

Special Senses: Tinnitus.

Incidence Less Than 1% - Causal Relationship Probable:

(Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are *italicized*.)

Body as a Whole: Malaise, swelling of lips and tongue, photosensitivity, *anaphylaxis*, anaphylactoid reactions.

Cardiovascular: Hypertension, congestive heart failure.

Digestive: Vomiting, jaundice, melena, *esophageal lesions*, aphthous stomatitis, dry mouth and mucous membranes, bloody diarrhea, hepatitis, *hepatic necrosis, cirrhosis, hepatorenal syndrome*, appetite change, pancreatitis with or without concomitant hepatitis, *colitis*.

Hemic and Lymphatic: Hemoglobin decrease, leukopenia, thrombocytopenia, *eosinophilia*, hemolytic anemia, *aplastic anemia, agranulocytosis*, purpura, *allergic purpura*.

Metabolic and Nutritional Disorders: Azotemia.

Nervous System: Insomnia, drowsiness, depression, diplopia, anxiety, irritability, *aseptic meningitis, convulsions*.

Respiratory: Epistaxis, asthma, laryngeal edema.

Skin and Appendages: Alopecia, urticaria, eczema, dermatitis, *bullous eruption, erythema*

multiforme major, angioedema, *Stevens-Johnson syndrome*.

Special Senses: Blurred vision, taste disorder, reversible and irreversible hearing loss, scotoma.

Urogenital: Nephrotic syndrome, proteinuria, oliguria, *interstitial nephritis, papillary necrosis, acute renal failure*.

Incidence Less Than 1% - Causal Relationship Unknown:

(The following reactions have been reported in patients taking diclofenac under circumstances that do not permit a clear attribution of the reaction to diclofenac. These reactions are being included as alerting information to physicians. Adverse reactions reported only in worldwide marketing experience or in the literature, not seen in clinical trials, are considered rare and are *italicized*.)

Body as a Whole: Chest pain.

Cardiovascular: Palpitations, *flushing*, tachycardia, premature ventricular contractions, myocardial infarction, *hypotension*.

Digestive: Intestinal pertoration.

Hemic and Lymphatic: Bruising.

Metabolic and Nutritional Disorders: Hypoglycemia, *weight loss*.

Nervous System: Paresthesia, memory disturbance, nightmares, tremor, tic, *abnormal coordination, disorientation, psychotic reaction*.

Respiratory: Dyspnea, hyperventilation, edema of pharynx.

Skin and Appendages: Excess perspiration, *exfoliative dermatitis*.

Special Senses: Vitreous floaters, night blindness, amblyopia.

Urogenital: Urinary frequency, nocturia, hematuria, impotence, vaginal bleeding.

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Illinois Medical PSO

(Continued from page 1)

support the PSO's capitalization drive," said ISMS President Sandra Olson, MD. "It was a tremendous opportunity lost. When the PSO Board went out to recruit physicians to invest in making the PSO a viable force, our commitment went unmatched. That left us unable to build the kind of physician-owned, physician-directed PSO that would have given us the independent, objective information source we need to compete in a free marketplace and ultimately to reassert control over our own profession."

To ensure physician ownership of the company, stock was offered only to Illinois physicians. More than 100 presentations were made to physicians across the state – at county medical societies and other physician meetings – to explain how the Illinois Medical PSO would function and how physicians could invest. Funds invested during the offering have been held in escrow and will be returned to physicians in keeping with the terms of the escrow arrangement.

The goal of the offering was to raise enough capital to implement an independent, physician-directed, for-profit corporation, providing physicians with support in negotiation and contracting, practice development, administrative and financial planning and capital formation. Doctors could have purchased customized services including the compilation of outcomes data and the evaluation of their patient base, fee schedules and expansion opportunities, Dr. Fesco said.

Information systems and administrative expertise are typically offered by management services organizations like the Illinois Medical PSO, according to a study published earlier this year by the Michigan State Medical Society. The study found that MSOs need to begin with a strong capital base because operating deficits are common during their first few years. Undercapitalization can be a problem if physicians are unwilling to make more than a modest investment in physician-owned MSOs, according to the study. As one physician-owner told the study's authors: "Physicians have tended to be fixated on salary and cash rather than equity. They need to better understand the long-term value of equity."

The ISMS House of Delegates had repeatedly directed the ISMS Board of Trustees to move forward in developing the PSO incrementally. For example, research was conducted over two years and included surveying physicians, studying market trends and developing a business plan. That research showed that physicians wanted to maintain their clinical independence and control over patient care. The PSO was intended to offer administrative support so that physicians could establish and lead entities capable of contracting with managed care organizations.

The need for those services still exists, Dr. Olson said. "Despite this setback, the PSO will continue to explore how and if it can provide you the services you've told us you need. The PSO Board will now investigate the market and see if an alternative arrangement can be reached with an outside vendor that would respect the PSO's basic philosophy of physician independence." ■

Women in managed

(Continued from page 1)

type of physician," said ISMS President Sandra Olson, MD, citing a 1993 Gallup Poll. "This law will protect the choice of women who want to access the physician they see the most and know the best – their obstetrician or gynecologist." The ISMS House of Delegates adopted a policy similar to this legislation at its 1995 meeting and reaffirmed that position in 1996, she added.

The law states that women must be able to designate a participating "woman's principal health care provider" who is defined as a "physician licensed to practice medicine in all of its branches specializing in obstetrics or gynecology."

Managed care plans and women have some options available to them as the new law is implemented, according to ISMS legal counsel. Plans must allow

women to choose a principal health care provider. But plans can permit women to choose one physician to serve as both their principal health care provider and their primary care physician, or to select two different physicians, with one being a principal health care provider and the other their primary care provider. But if women fail to choose a principal health care provider, they will not be assigned one by the plan. That's why patient education is so important, Dr. Olson said: "As physicians, we need to understand how this new law will affect our practices and be able to explain the new benefit to any patients who ask for clarification."

The potentially confusing referral and prior approval processes used by some managed care plans make it especially important for women to understand their right to directly access their obstetrician or gynecologist. "Considering all of the information available to patients about their health plans, we need to

make sure the provisions of this law aren't overlooked," Dr. Olson said.

Although the law requires that women have direct access to their participating principal health care provider, it doesn't mandate coverage of all obstetric and gynecologic services, according to ISMS legal counsel. Plans that would normally require obstetricians or gynecologists to gain referral authorizations so that patients can get certain specialized services can still require those approvals under the law.

The law applies to patients covered by individual or group policies for accident and health insurance or managed care plans as long as those policies were amended or renewed after the Nov. 14 effective date. Also covered are Medicaid recipients; employees of county, municipality and state government and other government bodies; and individuals insured by companies normally exempt under ERISA. ■

State Democrats

(Continued from page 1)

Kent (D-Springfield), a former legislative lobbyist for the Illinois State Bar Association. In addition, Ricca Slone (D-Peoria Heights), who is married to a radiologist, will serve her first term after defeating her opponent Walter Hellstrom Jr. (R-Bartonville).

Those who defeated incumbent representatives are M. Maggie Crotty (D-Oak Forest), who beat Rep. Jack O'Connor (R-Palos Heights); Jim Brosnahan (D-Evergreen Park), who beat Rep. Maureen Murphy (R-Oak Lawn); Kevin McCarthy (D-Orland Park), who beat Rep. John Doody (R-Homewood); Michael Giglio (D-Lansing), who beat Marvin Lyzenga (R-Lansing); George Scully Jr. (D-Flossmoor), who beat Rep. Flora Ciarlo (R-Steger); and Mary O'Brien (D-Coal City), who beat Rep. Steve Spangler (R-Newark). Other winners in heated races include Rep. Michael McAuliffe (R-Chicago), Renee Kosel (R-New Lenox), Rep. Eileen Lyons (R-

LaGrange), Rep. Jerry Mitchell (R-Rock Falls), Rep. Richard Myers (R-Macomb) and Rep. Mike Bost (R-Carbondale).

In the Illinois Senate, Republicans maintained a majority but lost two seats. After serving in the Illinois Senate since 1979, Sen. Aldo DeAnglis (R-Olympia Fields) lost to his Democratic challenger, Deb Halvorson (D-Crete). Terry Link (D-Vernon Hills) defeated his opponent, Tom Lachner (R-Lake Bluff), to win a vacant seat.

In two other contested races, however, Republicans won narrowly. Sen. Dave Luechtefeld (R-Okawville) beat his challenger, Barbara Brown (D-Chester), and Christine Radogno (R-LaGrange) defeated her opponent, Nancy Kenney (D-LaGrange). In two other Senate races highlighted previously in Illinois Medicine, Republicans also won. Sen. Dave Syverson (R-Rockford) was elected to another term, defeating his challenger, Carol Jambor-Smith (D-Rockford). Walter Dudycz (R-Chicago) also will serve another term after winning over Robert Martwick (D-Norridge). ■

In the U.S. Senate race, U.S. Rep. Richard Durbin (D-Springfield) defeated his opponent, Al Salvi (R-Wauconda) to win the seat vacated by Paul Simon.

In key races for the U.S. House of Representatives, Rep. Rod Blagojevich (D-Chicago) defeated incumbent Rep. Michael Flanagan (R-Chicago) in the 5th District. Danny Davis (D-Chicago) defeated four challengers to win Rep. Cardiss Collins' seat in the 7th District. In the 20th District, John Shimkus (R-Collinsville) defeated Jay Hoffman (D-Collinsville), a representative to the Illinois House.

At a press conference in Springfield on Nov. 6, Gov. Jim Edgar responded to the election results: "We may not see as much agreement on as many issues as we've seen in the last two years among the two majorities and the governor's office. But I'm hopeful that both Republicans and Democrats in the General Assembly will want to do the basic things that need to be done in state government and [that] we'll get our business done in a reasonable amount of time." ■

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • DECEMBER 6 19

IDPH updates HIV guidelines

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ISMIE earns upgraded B+ rating from A.M. Best Co.

CHANGE: Rating agency calls ISMIE 'leading provider of professional liability insurance for physicians in Illinois.' BY DEBORAH PREISER

[CHICAGO] Calling the Illinois State Medical Inter-Insurance Exchange "the leading provider of professional liability insurance for physicians in Illinois," the national rating agency A.M. Best Co. recently upgraded ISMIE's rating to a "B+" or "very good."

"We are very pleased with this upgraded rating," said Harold Jensen, MD, chairman of the ISMIE Board of Governors. "A.M. Best Co. assigns this rating to companies it considers 'secure.' Best understands we'll be here for Illinois physicians — [that] we won't disappear."

The upgraded rating came after ISMIE representatives met with A.M. Best financial analysts on Oct. 24 at Best's headquarters in Oldwick, N.J. The representatives shared ISMIE's latest 1996 interim



Dr. Jensen

financial results in the expectation of gaining a higher rating than the previously assigned "B."

The new "B+" rating reflects ISMIE's "improved operating results, adequate loss reserves and strong position in the Illinois medical malpractice market," according to A.M. Best.

Prior to 1995, ISMIE was assigned a nonrating of NA-6 by A.M. Best, since the rating company didn't have a rating procedure to apply to ISMIE's European reinsurers. Such a procedure was subsequently developed, and in 1995 ISMIE received its first A.M. Best rating, which was a "B."

In the October presentation, ISMIE was able to show favorable operating results. "[Best was] also impressed with ISMIE's good reputation and its strong commitment to serve members of the medical society and represent physicians in the state," said one of the presenters.

"We love the 'B+' rating. It best exemplifies who we are," Dr. Jensen said. "The upgraded 'B+' rating should assure ISMIE policyholders that this is a strong, secure company that can pay any and all claims against them." Dr. Jensen explained that to get an "A" rating, an insurance company must typically show high profitability, which is not an objective for ISMIE. He added that if an "A" rating can be obtained

(Continued on page 15)



David Hathcox

AFTER WINNING the AMA's 1996 Dr. Nathan Davis Award in Washington on Nov. 20, U.S. Rep. John Porter (R-10th) (left) of Illinois is congratulated by one of his nominators, M. LeRoy Sprang, MD, chairman of the ISMS Board of Trustees. Porter was honored for his promotion of medicine and public health.

ISMS releases report on Illinois HMO spending data

DATA: Information may help physicians and patients make choices. BY JANE ZENTMYER

[CHICAGO] Late last month, ISMS released a report that shows that the amount that HMOs spent on health care services in 1995 ranged from as low as 47 percent of their total income to as high as 149 percent of their total income. Administrative costs ranged from 3.9 percent of total income to 227 percent of total income. In general, those HMOs that earned the most as a percentage of income spent the least as a percentage of income on medical care, according to the report. Physicians may get the document from the ISMS Web site at (<http://www.isms.org>) or by calling ISMS at (800) 782-ISMS or (312) 782-1654.

"Physicians and consumers can look at these results, assess if a plan's profits and administrative expenses appear to be in a reasonable balance, and determine whether a plan provides

adequate health care services for the dollars the plan takes in," said ISMS President Sandra Olson, MD. "This study presents objective data on the HMOs and gives physicians some of the information they need to answer their own questions or questions from patients about a particular HMO."

The data was extracted from reports provided by the 37 HMOs that served Illinoisans in 1995 and filed with the Illinois Department of Insurance as required. Statistics include the total income of each HMO in 1995, the amounts that were spent on medical care and administration and the remaining profit. In reviewing these figures, physicians can determine whether HMOs are using a high percentage of total income for patients' health care, profits or administrative expenses like rent and equipment

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what to expect
as managed
care matures



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IMPAC works to elect candidates who are friends of medicine

RESULTS: It's not too early to look ahead to primary elections. BY JANE ZENTMYER

[CHICAGO] Perhaps everyone isn't happy with the outcome of every race in the Nov. 5 general election, but the Illinois Medical Political Action Committee achieved many of the results it wanted. Most of the physician-friendly candidates supported by IMPAC were winners. That's because IMPAC worked hard during the months before the election to help those candidates by providing financial contributions and volunteers, said Jere Freidheim, MD, IMPAC chairman.

"Despite the change of power in the [Illinois] House, IMPAC's election spending was very much on target and in support of friends of medicine," Dr. Freidheim said. "In the Illinois General Assembly, \$84 out of [every] \$100 went to winners.

In the IMPAC-supported races that were unsuccessful, we backed staunch supporters of tort reform who were in heavily targeted districts. And while we didn't win every race, we can certainly be proud of our successes."

Among those successes are two physicians' spouses who are members of the ISMS Alliance and who defeated their opponents to win two-year seats in the Illinois House. Incumbent Rep. Gwenn Klingler (R-Springfield) will serve her second term after beating her challenger, Marylou Lowder Kent (D-Springfield), the former legislative lobbyist for the Illinois State Bar Association. Ricca Slone (D-Peoria Heights), a radiologist's spouse,

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IDPH updates HIV guidelines

PROTECTIONS: Recommendations reduce risk of transmission from pregnant women to their unborn children. BY JANE ZENTMYER

[SPRINGFIELD] The Illinois Department of Public Health released late last summer its revised recommendations for reducing the risk of HIV transmissions from women to their unborn children. "We [first issued guidelines] in 1991, and we told doctors at that time if there were changes that came about, we would change the recommendations based on what science had learned," said IDPH spokesperson Tom Schafer.

The updated recommendations incorporate information from clinical trials that have shown that azidothymidine can reduce the chances of HIV transmission from a mother to her unborn child. The document outlines treatment recommendations based on a report from the U.S. Public Health Service Task Force, which provided physicians with information to start discussions with pregnant women about the use of AZT to reduce perinatal transmission.

AIDS cases among women of reproductive age in Illinois and throughout the country are increasing, according to data in the recommendations. Among Illinois women of reproductive age, the number of AIDS cases increased from 66 in 1990 to 316 in 1995. Nationally, the incidence of AIDS in women in this age group rose from 4,097 in 1990 to 11,154 in 1995.

Also covered in the recommendations

are patient education, counseling, testing and follow-up services for HIV-positive women and infants. The guidelines also address information doctors should discuss with patients, such as high-risk behaviors.

IDPH recommends that "universal HIV counseling and voluntary, confidential HIV testing with informed consent should be the standard of medical care for all pregnant and postpartum women and for women who have practiced high-risk behavior(s)." The guidelines also recommend that parents or legal guardians have the option of testing for their newborns. The ISMS Board of Trustees endorsed the revised document at its September meeting. ISMS House of Delegates policy supports HIV testing for women early in pregnancy and appropriate treatment for pregnant women who test positive for HIV.

IDPH also based its revisions on guidelines developed by the U.S. Centers for Disease Control and Prevention, which made Illinois eligible for a supplemental appropriation from the federal government to help implement the guidelines, said Chet Kelly, chief of IDPH's AIDS Activity Section.

The recommendations took on greater import in light of a recent amendment to the Ryan White CARE Act. That amendment states that by 1998 the U.S. Secre-

RECEIVING THE 1996 Edwin S. Hamilton Interstate Teaching Award is J. Roland Folse, MD, of Springfield. The plaque was presented by ISMS President-elect Jane Jackman, MD, at the Nov. 12 meeting of the Sangamon County Medical Society. The award is based on service as a teacher and practicing physician.



Ron Ackerman

tary of Health and Human Services must, by consulting with states and experts, determine how extensive mandatory HIV testing is nationwide for infants whose mothers have not undergone prenatal HIV testing.

If the HHS secretary determines that mandatory testing has become routine, states have until March 2000 to meet one of three conditions to receive their Title II funding: demonstrate that 95 percent of all pregnant women who seek and receive prenatal care before their 34th week of pregnancy have been tested for HIV; show a 50 percent reduction in the rate of statewide pediatric AIDS cases per 100,000 live births, comparing the most recent information available with 1993 data; and implement a program of mandatory testing for newborns. Illinois' Title II funding amounted to \$5.6 million this year, said Kelly.

The law is silent on what happens if

the secretary determines that mandatory testing has not become routine, said Joseph O'Neill, MD, associate administrator at the U.S. Health Resources and Services Administration for AIDS. "We do not believe we have the legal authority to withhold funds, but we would still be doing everything we could administratively to reduce perinatal transmissions."

"The concept is that if these recommendations are implemented widely, they become essentially a routine part of prenatal care and will have the effect of reducing perinatal transmissions," Kelly said. "It's too early to tell [if they will work]. But I don't think it's unreasonable to expect that we will be able to meet one or more of the three requirements."

Physicians may get a copy of the recommendations by calling (217) 524-5983 or writing to the AIDS Activity Section, IDPH, 525 W. Jefferson, Springfield IL 62761. ■

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Brochure explains physicians' legal obligations to patients with specific disabilities

[SPRINGFIELD] A brochure available from the Illinois attorney general's office covers the legal obligations physicians have to patients who are deaf, hard of hearing or speech impaired.

"Our feeling is people really want to do the right thing, but they do need help," said Elaine Hoff, the attorney general's policy adviser for disability rights. The four-page brochure addresses basic questions physicians might have when attending to patients who have special communication needs, she added.

The brochure explains that the Americans with Disabilities Act requires health care providers to communicate just as effectively with those who are deaf, hard of hearing or speech impaired as they would with patients without

those disabilities. The physician and the patient must agree on what will be needed to provide effective communication and who will provide it, Hoff said.

The brochure answers questions that health care providers typically ask the attorney general's office. Included are the definition of an individual who is deaf, hard of hearing or speech impaired; the auxiliary aids and services that physicians can provide for their patients; physicians' responsibility to pay for these services; and tax credits available to physicians who provide such services.

To get the brochure, physicians may contact Hoff at (217) 524-6575 or the Illinois attorney general's office, 500 S. Second St., Springfield, IL 62706. ■

Learn the business side of medicine

Residents planning to begin practice in another year or two, as well as physicians anticipating career changes, may register now for "Paving the Way to Practice: The Business Side of Medicine." This seminar, sponsored by the ISMS Resident Physicians Section, will be held at the ISMS office in Springfield on Feb. 8, 1997, from 9 a.m. to 4:30 p.m.

Led by consultant David Schmiede, president of Medstrategies Consulting Group, the seminar explores employment opportunities, interview strategies, contract analysis and negotiation skills. It covers how to evaluate an employment contract and professional liability insurance. Personal financial planning, including debt management, is also part of the program.

For residents who are undecided about the practice structure they want, Schmiede reviews the benefits and drawbacks of solo, group and hospital-based practices, as well as careers in managed care and academic settings.

For ISMS members, a registration fee of \$50 is required by Jan. 31, but the total \$50 fee will be refunded at the door. For nonmembers, the fee is \$50 with \$40 refunded at the door. For more information, contact the ISMS Resident Physicians Section at (312) 782-1654, ext. 1287.

Program explores what to expect as managed care matures

FUTURE: Physicians and patients will need to adjust. BY CHRIS PETRAKOS

[OAKBROOK TERRACE] Managed care is the wave of the future everywhere, but in some parts of the country it's already dominating health care delivery. What can physicians in Illinois, especially Chicago, expect as the managed care market here matures in the next five years? That question was taken up at the fall conference of the Illinois Association of Health Maintenance Organizations held Nov. 6 in Oakbrook Terrace. The conference also revealed what consumers want in health care and how to improve consumer satisfaction.

Physicians will have to adjust to patients who are increasingly savvy about their clinical care and know how to get the most out of their health plans, according to speaker Mason White, director of strategic information and customer systems at Health Partners, a Minneapolis-based HMO.

*In the future,
physicians will have
to invest in
information and
communicate better.*

Minneapolis has a high penetration of managed care, and three major plans now control 80 percent of the market, White said. Almost all primary care physicians are aligned with a group, and specialty physicians are rapidly following suit. Such a mature market offers Chicago a glimpse of the future. Companies like Health Partners have begun to actively empower Minneapolis-area consumers, White explained. For example, interactive kiosks are rolled in and out of employee work sites. With a few key-strokes, consumers can get information on a physician's office location and public transportation to get there, hours of service and even patient ratings of performance.

"What happens is that we as a health plan begin to take on a very different role," White said. "The role of the health plan changes from one of being a marketer to the employer to being a marketplace facilitator to consumers when they are trying to make a choice within the health plan."

As markets like Chicago grow, more

communication between health plans and providers will be necessary, noted Carron Maxwell, practice manager of Towers Perrin Integrated Health Systems Consulting in Chicago. The rapid advances of medical technology will mandate faster approval of new therapies. Most health plans have medical policies that are five to 10 years out of date and

have a highly questionable scientific basis, Maxwell said. Low price and access, so highly prized in early managed care markets, "will only be the ticket to the game. [They're] not going to differentiate anybody in the future. Quality of care and the quality of administrative services to the individual customer are going to be the drivers."

Maxwell predicted that in addition, physicians will have to reorganize their basis for compensation. Most group practices still distribute income according to productivity and seniority, which means that their fit with managed care organizations is about as bad as it

can get, she said. Physicians need to be rewarded for efficiency and customer service, Maxwell added. "In the future, physicians will have to invest in information and communicate better; and they have to recognize their patients not just as patients, but as customers. And, finally, they'll need to be aware of the group buyer who stands behind many of their individual [patients]."

Understanding what satisfies patient-customers in managed care plans is a necessary but not often easy task, conference speakers said. The key to understanding variations in satisfaction lies in

(Continued on page 10)



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REPORT for Illinois Physicians

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INCORRECT BILLINGS FOR BUNDLED HOSPITAL SERVICES

The Medicare program has recently learned that some physicians have been billing incorrectly for services provided to hospital patients. Section 1862(a)(14) of the Social Security Act provides that every service to hospital inpatients and outpatients, except for the professional services of physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists, as well as qualified psychologist services must be provided by the hospital directly, or by others under arrangements made by the hospital, and **only the hospital may bill its Medicare intermediary for the services.** If the services are not provided and billed for in this way, they are not covered by Medicare. This is sometimes referred to as the hospital "bundling" provision. This provision is applicable to all hospital patients where a Medicare payment can be made to the hospital, including patients in psychiatric hospitals.

This means that services and supplies that would normally be covered "incident to" in an office setting, such as the services of nurses and other clinical assistants that you hire and supervise, are not billable by you in hospital settings. Therefore, if you utilize the services of your own employees in a hospital setting and you merely supervise their services, you are not eligible for a payment from Medicare. Although your employees might meet the supervision and employment requirements generally applicable to "incident to" services in other settings, their services are nevertheless not payable as incident to services to you when furnished in a hospital setting. Their services would only be payable to the hospital, because of the bundling provisions described above, but the hospital could in turn purchase the services from you when furnished in a hospital setting. Also, you are not eligible for a payment from Medicare because supervision alone does not constitute a reimbursable practitioner service. You must personally perform the practitioner service for which you bill in order for it to be payable in a hospital setting. If you do not personally perform the service, you are not entitled to any practitioner payment.

When your staff provides services to hospital patients (such as the services of nurses or therapists, diagnostic tests, etc.), the Medicare payment for those services is included in the Medicare payment to the hospital. You may not seek payment from the beneficiary for such services. You may, however, seek payment from the hospital. Neither you nor the hospital may charge the beneficiary. Section 1866(g) of the Social Security Act authorizes civil money penalties for any person who bills for services in violation of the bundling requirement; this provision applies to improper billings of the beneficiary as well as to improper billings to a Medicare contractor.

Please feel free to contact the Health Care Service Corporation, the Medicare A intermediary and Part B carrier for Illinois, at (313) 225-8222, if you have any questions regarding this article.

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EDITORIAL

Accountability

On a recent television magazine program, an interviewer talked to people who were engaged in the latest trend for the health-conscious – smoking cigars. Many had just worked out at the gym before stopping by the cigar bar, where they were sipping cognac and puffing away. “Cigars aren’t as dangerous as cigarettes because you don’t inhale,” said several patrons.

Even a cardiac specialist quoted in the Wall Street Journal admitted he had been sucked into the trend by seductive marketing and social pressure. But he conceded the reality: The risk of lung cancer is less with cigars than cigarettes, but it still exists, and cigar smokers are at greater risk than cigarette smokers for cancer of the lip, mouth, pharynx, larynx and esophagus. The Journal quoted a public health official, who said the 1995 U.S. consumption rate was 2.5 billion cigars and predicted a rise in 1996 – the third consecutive year of increase after a three-decade decline.

The smoking habits of young people were cited as a factor in the projected leveling off or even increase in the cardiac death rate in the United States. Researchers at the American Heart Association’s annual meeting said that our record of 20 years of declining deaths from heart attacks is being reversed by adolescents’ smoking and other unhealthy behaviors.

A survey released by the Centers for Disease Control and Prevention last

month said that more than 5 million children in the United States face premature death from smoking-related diseases if current trends continue, reported the Chicago Tribune. Smoking-related deaths could result in about \$200 billion in health care costs, the CDC predicted.

It may seem as if we’re losing ground in the war on tobacco, but Illinois recently took a step to reclaim some of it. In November, Attorney General Jim Ryan filed a lawsuit against the tobacco industry and other entities who acted on the industry’s behalf. The suit alleges that for years the defendants deceived Illinoisans and stifled competition, illegally targeted minors and forced state taxpayers to unfairly incur costs related to the health care of Illinoisans. It seeks injunctive relief and hundreds of millions of dollars in restitution, penalties and damages for Medicaid payments, the cost of health insurance for state employees and the profits made from illegal tobacco sales to minors. The lawsuit also asks that the defendants be forced to pay for a corrective public education campaign and smoking cessation programs in Illinois.

“This is a very complex lawsuit with a very simple goal,” Ryan said. “We want the defendants to follow the law, to tell the whole truth and to repay those who have been harmed by their conduct.”

Responding to criticism of the lawsuit, Ryan said, “This action is pro-children, pro-taxpayers and pro-consumers.” It’s also pro-health care.

PRESIDENT'S LETTER

Election reflections

Sandra F. Olson, MD



Isn't this election a message that voters want power to be balanced and shared?

Well, the elections of 1996 are finally over. Aren't you glad? It appears that the American people are. Anyone I've talked to says, usually in a tone of disgust, “Thank God, I won't have to listen to or watch those miserable political ads anymore.” This election was not our finest hour. The mudslinging accelerated; the accusations of impropriety flew furiously; and surly, smart-alecky campaign workers like James Carville delighted in capturing national media attention as a forum for their proselytizing. Whether you are glad or sad at the outcome, I venture to say you wish the people who won and will be in office would get on with the business of government at every level and accomplish something good for the citizenry.

Let's recap some of the messages we can learn from this election. Voter turnout was the lowest since 1924 – only 49 percent of those eligible showed up at the polls. This fact of voter apathy speaks for itself. The majority of people in this country just don't get worked up about the political scene or devote much attention to the candidates or the details of their platforms. Earlier this year, a Washington Post survey showed that only 24 percent of respondents could name both their senators. However, our citizens sit up and take notice when there is an issue of direct interest or impact to them – they relate to their self-interest, which is understandable and often is reflected in their concern about local races.

We are a country of shifting political and ideological conflict. We decry too much government, but we demand that it be there when we need it. After all, we pay for it, so we have a right to demand its services, however inefficient and wasteful at times they may be.

So here we have a schizophrenic attitude based on our own perceptions and personal values. But doesn't this nation reflect a coalescence of individual beliefs and desires that ultimately fuels the

engine we call an assembly, congress, house of delegates or council? And that's what we've developed and codified in the blueprint for this process, a document called the Constitution.

So how does this situation reflect the voters, who have become less party oriented and more focused on ideology? Isn't this election a message that voters want power to be balanced and shared? Democracy means that power is delegated by those who ultimately control it – in this case, you, the voters, to a delegated person, who may not always be trusted but who is charged. Often, sadly enough, we make this choice between candidates based on the one least likely to be offensive and contrary to our views. When did you last develop exuberance and unbridled enthusiasm for a political persona?

But we come down to an important theme being expressed by citizens: Get on with it, cooperate, be moderate, don't be extremists, stop talking and do something! Isn't it striking that both parties are now saying, “Let's work together; the people have spoken; put political squabbles aside”? We need to reinforce the message the electorate sent to lawmakers, step up and work on policy, focus on the issues and do something substantial. On “Meet the Press” on Sunday, Nov. 17, Rep. Dick Armey articulated this view repeatedly. Since Nov. 5, bipartisanship and cooperation have become buzzwords. President Clinton knows he doesn't dominate Congress, so naturally he is talking cooperation – even going so far as to suggest he may appoint a high-ranking Republican to his cabinet or ask Bob Dole to head a Medicare commission. The Republicans are also voicing these sentiments. The people have said they want a balanced budget; they want Medicare saved; and they want to do something about taxes. The way in which the politicians consolidate the views of their constituencies into balanced, productive results will determine our – and their – future.

GUEST EDITORIAL

HMOs dabbling in hocus-pocus?

By Joan Beck

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A cartoon in New Yorker magazine not too long ago showed a middle-aged couple meeting their new HMO primary care provider for the first time – a witch doctor in full regalia. “Frankly,” says the husband, “we had been hoping for someone a little more traditional.”

It's not witch doctors, yet. But the wrenching changes in medical care being rapidly forced on the public by for-profit HMOs do seem a little scarier this week, as a major health organization took a giant step away from mainstream medicine.

Oxford Health Plans Inc., called by the Wall Street Journal “one of the nation's largest and most influential managed care plans,” is setting up a huge network of providers to give its members what is loosely called “alternative medicine,” “natural remedies” or “naturopathic” treatment. It will also offer tai chi, hypnotherapy and other techniques as its alternative medicine network expands.

A number of other large health maintenance organizations are also adding alternative medical care, including massage therapy, herbal remedies, relaxation therapies, yoga, acupuncture and holistic treatment.

These are remedies that have not been subjected to the rigorous scientific testing required by mainstream medicine and are considered by many physicians to be quackery. Certainly, they raise questions about whether the HMOs' first priority is to provide the best health care – or the cheapest.

The major selling points of HMOs are that they will emphasize prevention of illness and encourage good health.

And they will use the best, most effective treatments, reducing the unnecessary care they argue is common in fee-for-service plans. In doing so, HMOs claim they can save enough money to pay executives handsomely, reward stockholders competitively and reduce costs to employers and insurers.

Managed health organizations, supporters claim, study medical research, define the best care and insist the doctors they use adhere to these protocols unless they get special permission to do otherwise.

Many also require that only drugs from an approved list be prescribed, often those for which the HMO has a discount arrangement with the manufacturer. Some plans resist adding expensive, new drugs to their formulary, even if there is medical evidence that they are better.

Most HMOs and health insurance companies have rules about how long patients can stay in a hospital after various kinds of surgery. For example, it took an act of Congress last month to force managed health organizations to allow new mothers to stay in the hospital for 48 hours following a normal birth, instead of being pushed out in as few as eight hours.

Ask executives of HMOs about such issues and they will usually respond by saying patients and doctors will just have to get used to it. Then they segue quickly into talking about how hard they work to provide “quality of care” and how they intend to prove that they do, indeed, give it.

So why are Oxford Health Plans (which intends to set up a network of 1,000 holistic providers and a division to sell herbs) and some other HMOs mov-



“I don't think saying that we provide the shortest hospital stays in the business is a good selling point.”

ing into alternative medicine?

It can't be to provide quality health care. By definition, alternative therapies don't meet the rigorous standards of scientific medicine.

The reason the chairman and CEO of Oxford gave the Wall Street Journal is “the demand by consumers to seek an alternative to conventional Western medical solutions.” Customer demand is also cited by other managed care organizations that are adding such services.

Millions of people do insist they have been helped by one or more alternative therapies. The fast-growing market is already estimated to be about \$50 billion a year.

But alternative medicine, by its very definition, does not meet the standards of care HMOs purport to be offering, no matter how enthusiastic its supporters may be. And managed care organizations show little or no interest in doing the scientific research that would prove these claims and bring effective alternative therapies into the mainstream.

For HMOs to say they are providing alternative care because of consumer demands raises other questions. If managed care organizations do respond to consumer demand, why was it necessary

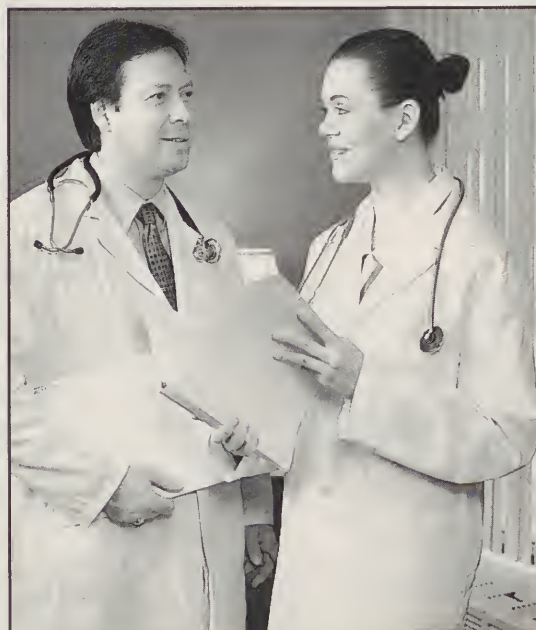
to go to Congress to force them to meet patients' demands for two days of hospitalization following childbirth? Why do some patients go to court to get coverage of expensive procedures HMOs disallow? Why are physicians forbidden to tell patients about some costly treatments they might then want?

What HMOs do see in alternative medicine is most likely another stream of profit. Those that do offer access to alternative therapies are charging an extra 2 or 3 percent on their premiums. Alternative treatment is less expensive than mainstream care. And Oxford, for example, will allow patients to go directly to an acupuncturist or naturopathic practitioner without seeing and getting a referral from a primary-care “gatekeeper” as they must do to consult a cardiologist or oncologist.

The real danger comes if HMOs are tempted to allow – or even encourage – patients to use alternative medicine not just as an adjunct to mainstream medicine, but as a substitute. Herbal remedies or dietary supplements are a lot cheaper than treating cancer patients with expensive chemotherapy drugs, for example. And if they die sooner than they might otherwise, so much the better for the HMO's bottom line.

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ISMIE Update

Keeping patients satisfied

Addressing problems directly can reduce bigger problems in the long run.

BY JANE ZENTMYER

One constant in patient satisfaction is that it depends largely on open communication and the quick handling of patient complaints. There is, however, variation in the ways to accomplish those goals. For example, patients at the Elmhurst Clinic air concerns through an incident-reporting procedure set up in 1991 to improve service and reduce the risk of lawsuits. Whether patients are unhappy with how long they were kept waiting or disappointed with the outcome of a procedure, "we feel the patients come first, and if they're unhappy, we need to know it," said Keith Brown, DO, the clinic's chief medical officer. "We have to have input in order to improve. We encourage patients if they have any problems to let it be known so we can look into things."

One physician has even formed a patient advisory council. In 1972, Milton Seifert Jr., MD,

of Excelsior, Minn., developed the council to help resolve complaints and set or change policies based on input from staff and patients. He solicited council members by sending postcards to all his patients, according to an article in the Sept. 9 issue of *Medical Economics*. Of the 200 people who responded, about 50 attended the council's first meeting, and there are about 50 members on the council today. When a patient complains about the practice, the council serves as a mediator. "This is really an extension of the

doctor-patient relationship," Dr. Seifert told *Illinois Medicine*.

Although Dr. Seifert's approach may not be practical for all physicians, doctors should develop some procedure or system for handling patient complaints. There's no doubt that doing so can lessen the chances of a lawsuit, said attorney Robert Baron with Rooks, Pitts & Poust in Joliet. "We do constantly meet people who went to a lawyer because they just had questions on their minds and the doctor didn't address



them correctly. One thing leads to another, and it gets into the hands of someone who manufactures a case, and all of a sudden, it gets out of hand."

Patients sue for myriad reasons, according to ISMIE information, including a personality conflict with the doctor or staff or the feeling that access to the doctor was restricted or vital information was withheld – situations that could be alleviated if recognized early on.

The four-site Elmhurst Clinic, a division of Elmhurst Memorial Health System, set up its reporting procedures to create structure and documentation in tracking patient complaints in the practice, according to Heather Doyle, the clinic's operations manager. Each complaint may be handled differently depending on its nature, but the clinic generally encourages patients to put their concerns in writing, she explained.

Patients document their concerns by filling out an incident report that asks for their name, the type of problem and the names of those involved. The form is then sent to the staff person most qualified to handle the situation. The patient is kept abreast of results by letter or a telephone call.

Dr. Brown said he recently dealt with a patient who was unhappy because she didn't get her biopsy results within a week. She felt that the nurse handling her telephoned request for the results lacked concern and exhibited a "laissez-faire attitude," he explained. Dr. Brown spoke with the physician and the nurse and made sure the test results got to the patient quickly. In addition, he saw to it that the nurse and her supervisor discussed the nurse's attitude. Dr. Brown also called the patient, explained how the situation had been handled and expressed appreciation that she voiced her concerns. In the end, the patient was satisfied, he said.

Dr. Seifert's advisory council took action to please patients by helping form a new policy: Staff members now tell patients how long they will be in a waiting room and ask them if they have other engagements in order to avoid any time conflicts. Open lines of communication among council members,

New rating for radiation oncologists

ISMIE has established a new specialty rating, along with lower premiums, for physicians who limit their practice to radiation oncology. Previously the radiology categories were separated based on diagnostic vs. interventional radiology procedures.

The new specialty category reflects the fact that radiation oncologists have a lower claim frequency than diagnostic radiologists. Radiation oncology has evolved from being a part of general radiology training to having its own residencies and boards.

Radiologists who specialize exclusively in radiation oncology and think they may qualify for this new rating should call the ISMIE Underwriting Division at (312) 782-2749 or (800) 782-4767. There is no charge to policyholders for processing this change.

MALPRACTICE ROUNDUP

Patient found partly liable for ignoring follow-up

A Pennsylvania jury found that a patient was 65 percent liable and his physician 35 percent liable for a delayed diagnosis of melanoma that led to the patient's death, according to the August issue of *Medical Malpractice Law & Strategy*.

In *Butts vs. Purkayastha*, the patient had seen the physician about a spot under his fingernail. The physician told the patient the spot was a chronic infection, removed the nail and asked the patient to return for follow-up treatment one month later.

The patient, however, didn't return for two years. He was then diagnosed with subungual melanoma, and his thumb was amputated. The cancer had metastasized to his liver and pancreas, and the patient died 18 months later. ■

Surgeon not negligent for continuing surgery

A California jury found a surgeon not negligent in continuing a patient's gallbladder surgery after the patient experienced cardiac arrest during the procedure, according to the September issue of *Medical Malpractice Law & Strategy*.

The surgeon alerted the anesthesiologist during the operation that the patient's blood was dark. The anesthesiologist, who was also sued, confirmed that the equipment was functioning correctly. The patient experienced cardiac arrest and was subsequently resuscitated. The surgeon then completed the procedure. The patient was in a coma for several days after surgery and underwent lengthy rehabilitation.

The patient claimed her condition was created by the trauma of the continued surgery, which she said should have ended when the cardiac arrest began. The surgeon said he acted within the standard of care because the patient had stabilized before he continued the surgery, and the jury agreed. The anesthesiologist settled with the plaintiff for \$75,000, the article said. ■

physicians and staff, and patients have helped avoid potential lawsuits, said Dr. Seifert, adding that all parties can air their concerns to get situations resolved.

Keeping up-to-date, detailed written records can also benefit staff and physicians, especially if a lawsuit develops, Doyle said. She recalled a situation in which a written record of a patient's phoned-in complaint and an explanation of the handling of the complaint helped her give accurate testimony when she faced that patient later in court. Documentation also helps staff track any trends or common complaints that might merit a procedural change. "If you don't have anything written, you're not going to be able to see what your trends are," she said.

Every complaint received by the Elmhurst Clinic requires positive comments or actions to make up for it, Dr. Brown said. He summarized the clinic's philosophy: "We try to minimize the negative and maximize the positive." ■

This information is reprinted, as space permits, from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

March 1996

Guy J. Dennis, Orchard Park, N.Y. – physician and surgeon license indefinitely suspended after being disciplined in the state of New York.

Ziyad A. Ghabra, Homewood – physician and surgeon license indefinitely suspended after being disciplined in the state of California.

Michael Gonzales, Highland Park – physician and surgeon license and controlled substance license placed on probation for one year for allegedly continuing to prescribe controlled substances after a patient failed to exhibit any apparent therapeutic benefit.

Benjamin M. Manalo, Northbrook – physician and surgeon license and controlled substance license revoked after being convicted of mail fraud relating to multiple fraudulent billings, and alleged narcotic violations relating to the prescribing of controlled substances that were not for legitimate medical purposes for multiple patients.

Joel Mayer, Indianapolis, Ind. – physician and surgeon license indefinitely suspended due to an inability to practice medicine with reasonable judgment, skill or safety.

Sunil Pandit, Saginaw, Mich. – physician and surgeon license reprimanded after being disciplined in the state of Michigan.

April 1996

Robert Bloom, Glenview – physician and surgeon license reprimanded for revealing confidential information regarding a patient.

Charles Leroy Dickens, Chicago – physician and surgeon license issued and placed on probation for 10 years after being treated for substance abuse and addiction on various occasions.

Jeffrey Kramer, Wilmette – physician and surgeon license reprimanded and fined \$2,000 for failing to keep records regarding the prescribing, dispensing and purchasing of controlled substances.

Charles Levie, Anna – physician and surgeon license and controlled substance license indefinitely suspended for habitual use of controlled substances as a result of physical illness.

Arturo Olivera, Chicago – controlled substance license placed on probation for two years for failing to keep complete and accurate records, failing to provide effective controls and failing to maintain an accurate inventory.

Joseph Shaheen, Alton – physician and surgeon license placed on probation for five years, and controlled substance license indefinitely suspended due to an alleged impairment problem due to excessive alcohol and cocaine ingestion for which he has received treatment, and allegedly submitting billings to Illinois Department of Public Aid for services not rendered.

May 1996

Mark A. Flood, Olympia Fields – physician and surgeon license and chiropractor license placed in a refuse-to-renew status after defaulting on an Illinois Student Assistance Loan.

Donald D. LaMarca, Elgin – physician and surgeon license revoked after being disciplined in the state of California.

Richard O. Ringewald, Chicago – physician and surgeon license and controlled substance license suspended for one month followed by probation for five years and fined \$10,000 after allegedly prescribing controlled substances for nontherapeutic purposes.

Jeffrey Rutgard, Fort Dix, N.J. – physician and surgeon license revoked after being disciplined in the state of California.

Thomas L. Stone, Rolling Meadows – physician and surgeon license reprimanded for making unprofessional comments to a female patient, which violated common standards of decency or propriety.

Franklin D. Swan, Oregon – physician and surgeon license reprimanded and controlled substance license indefinitely suspended for allegedly prescribing controlled substances for nontherapeutic purposes.

Morton Willcutts, Monmouth – physician and surgeon license indefinitely suspended due to outstanding Illinois tax liability for 1980, 1988, 1992, 1993 and 1994, and failing to file an Illinois income tax return for 1994.

June 1996

Matthew Tyler Brennan, Chicago – physician and surgeon license issued and placed on indefinite probation after providing a positive response to personal history questions on application.

Rakesh Chandra, Naperville – physician and surgeon license issued and placed on probation for two years after providing a positive response to personal history questions on application.

David L. Scheiner, Chicago – physician and surgeon license reprimanded for failing to procure a hematology consult for a sickle cell patient prior to surgery.

Yavarace Young, Alton – physician and surgeon license indefinitely suspended for refusing to release patients' medical records to a department investigator and Illinois state police officer when presented with properly executed releases.

July 1996

John B. Bellucci Jr., Wauconda – physician and surgeon license suspended for three years followed by probation for five years, and controlled substance license indefinitely suspended after being convicted of a felony, unlawful delivery of a controlled substance and allegedly failing to pay Illinois income tax for several years.

Janice M. Itson, Chicago – physician and surgeon license placed on probation after defaulting on an Illinois Student Assistance Loan.

Woo Young Kim, Sterling – physician and surgeon license placed on probation for two years, and controlled substance license placed on probation for five years for allegedly using various improper prescription practices including the preparation of an undated prescription, the failure to maintain a controlled substance prescription log, and excessive and non-therapeutic prescribing to patients not complaining of pain.

Petras Kisieličius, Cicero – physician and surgeon license reprimanded and controlled substance license placed on

probation for one year for allegedly prescribing Darvocet and Xanax for non-therapeutic purposes to an undercover investigator from the department.

Ajay Parghi, Salisbury, Md. – physician and surgeon license placed on indefinite probation after being disciplined in the state of Ohio.

Suzan Sakhuja, Chicago – physician and surgeon license reprimanded for allegedly failing to keep records sufficient for department requirements to document prescription and dispensing practices and controlled substance inventories.

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Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by β -adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however, no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patients sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral α -adrenergic blockade. These include anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

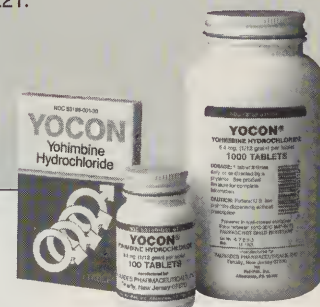
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence:^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage is to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01, 1000's NDC 53159-001-10, and blister-paks of 30's NDC 53159-001-30.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological Basis of Therapeutics 6th ed., p. 176-188. McMillan.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Helping students make the grade in residency selection

An interactive exercise shows prospective residents what to expect.

BY MINDY S. KOLOF AND DEBORAH PREISER



Medical students discuss what qualities lead to success in a pediatric residency. The session's facilitator was William Cannon, MD (center), assistant professor of medicine and pediatrics at the Loyola University Chicago Stritch School of Medicine in Maywood. In the photos on the facing page, aspiring family practice residents brainstorm with program directors.

Have you ever been fired? How do you influence someone to accept your ideas? How do you cope with the death of one of your patients? Is there anything you don't want me to know about you?

These were among the "stumpers" posed to 130 medical students Sept. 28 during the ISMS Medical Student Section's 10th annual "Preparing for Residency Interviews Seminar." Attendees benefited from a day chock-full of information ranging from explanations of the National Resident Matching Program and the American Medical Association's Fellowship and Residency Electronic Interactive Database Access System to tips on surviving the residency interview. In addition, the seminar featured a new element – an interactive session in which students participated in a mock residency selection.

To kick off the interactive session, students were grouped by specialty. Each group was led by a program director representing that specialty and discussed the qualities that physicians in that specialty should possess. "Residents gearing up to be surgeons thought qualities such as drive, dexterity and intelligence would be important for surgery," explained Michael Totaro, vice chairman of the ISMS Medical Student Section and the seminar's student organizer. "[The family practice] group thought intelligence was important, but a good bedside manner and a sense of

humor were other qualities they would look for."

After ranking the most important qualities from one to 10, the groups talked about how hospitals can best determine whether potential residents have those characteristics. "You'd probably have to rely on a personal interview to determine whether or not a person had a sense of humor," said Totaro, "while you could get a sense of a person's dexterity if they had belonged to a model-building club."

Finally, each group reviewed mock application files for three candidates, discussing the merits of each. The files included personal information such as extracurricular activities, excerpts of letters of recommendation, summaries of clinical evaluations and notes from the program director interview. The files were prepared by Michael Rainey, dean of student affairs at the Loyola University Chicago Stritch School of Medicine in Maywood, and were based on information supplied by medical students who had applied to Loyola University Medical Center in Maywood.

"Medical students got information from this mock selection process they would never have gotten anywhere else," Totaro said. "It's impossible to look at yourself in an objective manner, but when you've looked at other applications and discussed their flaws and pluses, you can understand how you'll be looked at as well."

"It's very useful for students to get a handle on



how they'll be viewed from the perspective of the people who evaluate students for residencies. I could definitely see light bulbs going on in the heads around the table," said Warren Wallace, MD, a seminar group program director and director of the selection committee for internal medicine residencies at Chicago's Northwestern Memorial Hospital.

"Anything we can do as a profession to educate students about the process of becoming a physician is very valuable," Dr. Wallace said. "How a residency committee ascertains what qualities are important to that specialty is not always that obvious." He added that the seminar's selection process was similar to the way his committee works and that the job can be daunting. For example, Northwestern receives about 1,000 applications from U.S. medical students and 3,000 to 4,000 applications from international medical students for about 50 internal medicine residency spots per year.

As in the past, the session "You and the Interview: Putting Your Best Foot Forward" was popular with students. The session began with a video taken earlier in the day that showed seminar participants industriously taking notes, talking animatedly, even absent-mindedly scratching their heads. Reactions to the clip ranged from embarrassment to laughter, but the point was well-received. "It's a way to get us all involved in the process of seeing how others see you," explained speaker Bob Hultz, a professional trainer with the Chicago-based company Bob Hultz Inc. "People are always forming impressions of you, but you can't be on all the time."

Mock interviews featured two students asking each other questions from a list of 60 stumpers. Attempting to keep their answers interesting, concise and no longer than 30 seconds proved a formidable challenge for the future residents. Asked his political views, a student from the University of Illinois in Peoria thought he'd play it safe by saying, "They tend to be on the conservative side." Hultz's instant analysis: "Answer was too short, almost begged the question."

"How do you keep from repeating your personal failures?" was the question posed to a student at the University of Illinois in Rockford, and she provided a thoughtful answer. "I try and analyze it and also have a large support group of friends to help me through it."

A student from the Chicago Medical School launched into a detailed explanation of how he handled receiving a grade lower than he expected. "Too long," observed Hultz. The same student came back

with a convincing reply to "What are your strengths in working with people of other racial, ethnic and social backgrounds?" by citing an example from his childhood in Los Angeles, "which has a large racial mix."

Hultz shared pointers for heading off potential problems. To make sure they're on time, for example, students should take an alarm clock to the hotel and plan ahead carefully. "Scope out how long it will take you to get from the airport to the rental car place to the hotel to the hospital, and then double that time, because something always goes wrong."

He advised students to watch what they eat and drink the night before. "Just a little wine the night before your interview might be all it takes to sleep through your alarm the next morning." In addition, he recommended that they be prepared by taking an extra pair of shoes, eyeglasses or contact lenses.

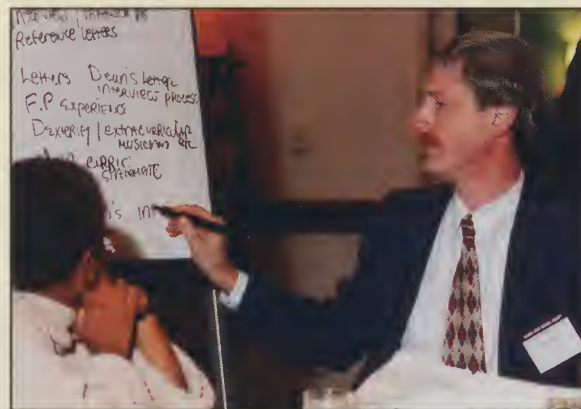
Hultz also suggested that students videotape themselves well before the interview. "You'll be amazed at what you see and how you can improve [your performance]." He warned against sitting with crossed arms ("a classic defensive posture"), leaning into their hands, pointing, playing with their hair or jewelry and slouching. As for what to do with their hands, he suggested that students "put one on top of the other and place them comfortably on your leg."

When in doubt, leave it out, Hultz said. "Say things in 30 seconds or less." To prove his point, he showed popular TV commercials and noted, "America's used to hearing and seeing information in short segments."

A panel discussion titled "What a Student Should Look for During an Interview" featured more advice from resident Betty Chang, MD, an internist at Northwestern Memorial Hospital, and Gretchen Kind, MD, chief resident in pediatrics at Loyola University Medical Center, veterans of the residency matching process. "Get the names and numbers of residents with whom you interview and call them back with questions," Dr. Kind said. "Ask to come back for a second look." She also urged students to ask a lot of questions: What are the strengths and weaknesses of your program? What can it offer me? How do you feel about pregnant women undergoing residency? How diverse is your student body?

Dr. Chang's final advice was to size up the hospital's residents. "Ask yourself if these are people you want to hang out with, because you'll be spending about 75 hours a week with them."

"I think it's a good idea for second- or third-year students to go through this seminar to learn how the process works before they send out their applications and go again as a fourth-year student to get a refresher course in interview techniques," said Balu Nataraajan, MD, former chairman of the ISMS Medical Student Section and an internal medicine resident at Northwestern. "If you've been through the seminar, you know what to expect. You're still nervous, but it's not so scary once you get there." ■



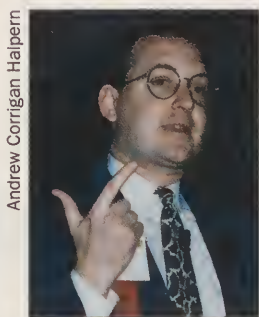
Photos: Perry Rech

Program explores

(Continued from page 3)

knowing that managed care, like any product, goes through stages – including emergence, maturation and decline, said Mary Kay Conlon, senior vice president of client services and consulting at Sachs Group, a health care information company in Evanston. Consumers value two factors – cost and convenience – at all stages, she said.

Chicago had only a 30 percent penetration rate as of 1994, according to the U.S. Health Care Financing Administration, so it is still a young market. Conlon



Baumruk

What is interesting is that satisfaction may vary significantly among employees of different companies using the same plan, said Raymond Baumruk,

said the bad news is that consumer satisfaction in Chicago has dropped over the past two years in areas such as the range of services and the access to urgent care.

who is with Hewitt Associates, a human resources consulting company in Lincolnshire. "One of the biggest findings in Chicago was that the same plan – same network, same doctors, similar plan design, similar costs – can have dramatically different satisfaction levels between two different employer populations. One reason for that may be that employees don't attach satisfaction [to] the plan itself, but [to] the employer."

Over the next few years employers will be less concerned about satisfaction and more concerned about the impact the plans are having, Baumruk predicted. For instance, employers will want to

know whether employees are using health care wisely, making informed decisions and getting preventive care, as well as whether the plan is delivering healthier employees, which increases productivity.

Consumer satisfaction can be tied to other factors, too, Baumruk said. Consumers who have a choice of health plans tend to be happier than those restricted to only one plan. And satisfaction generally rises the longer an employee stays in a given plan.

Preparation is another factor in keeping consumers satisfied. About 50 to 60 percent of his clients do a good job of educating their employees about their plans, said Baumruk. "But, if you look at the 40 percent of employers who don't do a good job, we see satisfaction at 25 to 30 percent less."

Hewitt Associates and the AMA are currently conducting a nationwide survey of 100,000 physicians that seeks doctors' opinions on the managed care plans with which they're affiliated. "Physician turnover is a big deal to employees," said Baumruk. "Our idea here is that plans that satisfy the employee, physicians and employers are the ones that are going to be around a few years from now."

Loyola renames children's hospital to honor donor

[MAYWOOD] With a comic ceremony that featured two "doctors" scaling down a five-story children's hospital to uncover the building's new name, officials christened the Ronald McDonald Children's Hospital of Loyola University Medical Center in Maywood. The new name, unveiled in early October, recognizes a \$10 million donation from Ronald McDonald House Charities to support children's health care at Loyola, according to information from Loyola.

The donation represents the largest non-estate gift ever given to the medical center or its parent university, Chicago's Loyola University. It is also the single largest grant ever presented by the Ronald McDonald House Charities, which has given \$125 million in grants to not-for-profit children's programs around the world in addition to supporting 175 Ronald McDonald Houses in 14 countries since 1974, the background material reported.

The children's hospital at Loyola is the first facility in the United States to be designated a Ronald McDonald Children's Hospital, according to the medical center.

"Ronald McDonald House Charities is committed to helping children, and Loyola is dedicated to providing excellent pediatric health care," said Kenneth Barun, president and chief executive officer of Ronald McDonald House Charities. "The shared vision of our respective organizations is to support this children's hospital in its commitment to be a world-class pediatrics facility, one that serves as a model for children's hospitals everywhere."

Loyola plans to raise an additional \$2.5 million for the children's hospital, said Joseph Sandman, vice president at Loyola University. The funds will continue the multimillion-dollar renovation that started a year ago with the development of a new pediatric intensive care unit that opened last month.

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ISMS releases report

(Continued from page 1)

costs. HMOs that spend the highest percentage of total income on patient health care are likely to have satisfied patients who will remain with those HMOs longer, resulting in a stable patient base for physicians.

Some of the HMOs with the highest percentages of total income spent on medical care and administration are newer, start-up plans that have low enrollment and that may be experiencing a short-term loss. Of the 37 HMOs, 29 were licensed before 1990, and 29 are for-profit companies.

The report's numbers are more meaningful for those HMOs that are larger and more established, according to the study. For those HMOs with more than 5,000 enrollees, the HMO that spent the lowest percentage of total income on medical care – 47 percent – also spent about 37 percent of its 1995 income on administration with 15.8 percent remaining as profit. The HMO that spent the highest percentage of total income on medical care – 98.9 percent – paid 58.4 percent for administrative expenses and experienced a loss of 57.2 percent. That HMO began operating in 1993, the report states.

By comparison, the California Medical Society released a similar report covering fiscal year 1993-94. In that mature managed care market, the two HMOs that spent the most on patient health care spent 96.5 percent and 94.5 per-

cent. The plan that spent the least on medical care spent 70.2 percent in that category and 16.9 percent on administration with 12.9 percent remaining as profit.

The Illinois report also includes data showing how often patients use the services available from their HMOs. The frequency of physician visits ranged from .32 to 17 per member per year. And, for every 1,000 HMO members, the plans provided between about 70 to 869 days in the hospital. These numbers, according to the study, can vary widely depending on the patient base of the HMO. For example, higher utilization rates would be expected from those HMOs that have more Medicare enrollees.

From 1994 to 1995, HMO enrollment in Illinois increased to 1.96 million, a jump of about 131,000 or 7 percent. Enrollment in 14 HMOs rose by more than 10 percent, seven by more than 30 percent, and four by more than 50 percent. Ten HMOs lost enrollees during 1995. Of those, five lost more than 10 percent, and four lost more than 30 percent.

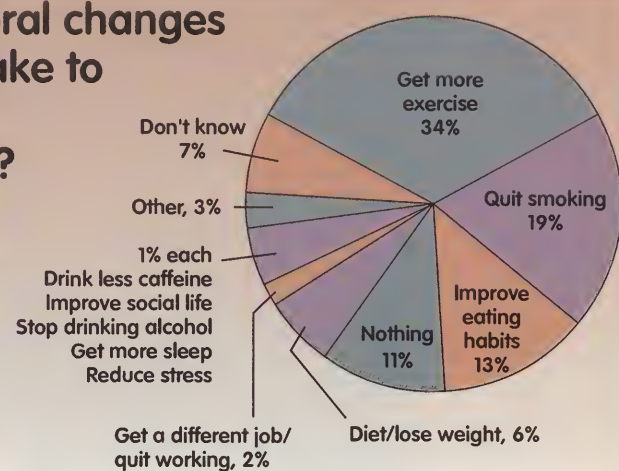
"There are big differences among HMOs in Illinois," Dr. Olson said. "In addition to helping physicians, these findings should help patients become better informed about what is available, ask better questions of the plans or their employers and get better value for their health care dollars."

The report also includes the HMOs' premiums, total revenues, assets and net worth, and lists HMOs that provided

What behavioral changes would you make to improve your overall health?

Number of respondents:
1,012 U.S. adults

Source: American Academy of
Family Physicians, 1996



coverage to Medicare and Medicaid enrollees in 1995.

Possible reasons for HMOs' loss of significant amounts of money include recent entry into the Illinois market, expansion in the Illinois market and a business plan projecting losses, and financial difficulty, according to an ISMS analyst. Researching the specific reasons behind HMOs' losses should help physicians determine which plans to avoid when they make contracting decisions.

The HMOs received a copy of the report and were asked to comment and verify the information. Of the 37 HMOs, 19 responded and their comments were incorporated into the study. Richard Bartsch, MD, senior vice president and senior medical officer of the Moline-based John Deere Family Health-

plan, said a report like this one should evaluate measures that create value in the health care system including health outcomes, patient satisfaction and cost. "Comparison of health plans is difficult," he said. "Health plans differ in many ways including benefits offered, disease burden of members, age and other demographics of patients, makeup of physician networks, the mix of insured and self-insured business and other business."

During 1996, more HMOs have started up, and more mergers and acquisitions have occurred, and their data will be included in a future ISMS report. ISMS is also exploring the availability of information related to patient satisfaction, outcomes and preventive care for inclusion in a future report. ■

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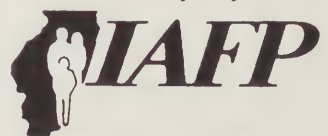
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(Continued from page 1)

will begin her first term when the Illinois General Assembly convenes in January.

When the Illinois General Assembly resumes next year, the Democrats will take control of the Illinois House with a 60-58 majority, and House Democratic Leader Michael Madigan will likely become speaker – a position he held for 12 years before the GOP took control of the House in 1995. In the Senate, Republicans lost two seats but maintained control with a 31-28 majority. While the shift in power diminishes chances for future tort reform, other health-related issues may not be affected as much.

Physicians and their spouses became involved in this year's local elections through the Medical Campaign Coordinator Program. Now in its 10th year, the program offers the assistance of volunteers to those candidates who have indicated they will be sympathetic to the views of medicine, said Pam Taylor, legislative affairs chairman for the ISMS Alliance. Volunteers take a hands-on role in such campaign activities as fund raising, stuffing envelopes and visiting voters at their homes. "[The program] worked out great," Taylor said, adding that volunteers worked in 11 races, and all but one candidate won.

We hope that in the not-so-distant future we will have every elected legislator going through the program at least once.

Alliance members also reminded physicians and their spouses to register to vote, particularly those who moved after the last election and needed to change their voter registration information, Taylor said.

Now, Taylor said, preparations are under way to begin the mini-internship program, which teams legislators and civic leaders with physicians so that policy-makers can see firsthand what physicians experience during a typical day. "If we invite the legislators to go through the program, they understand medicine," she said. "We hope that in the not-so-distant future we will have every elected legislator going through the program at least once."

Local physicians were also enlisted to sign support letters for 46 candidates in key races, Dr. Freidheim said. The physicians signed a letter that described each candidate and how he or she shared medicine's views. It encouraged physicians to talk about the candidate with their families, friends and neighbors. The letter then was mailed to all physicians in the district.

Although this election was completed just about a month ago, IMPAC is already anticipating the 1998 elections. In that general election, all the state's constitutional offices as well as all 118 members of the Illinois House and 40 of the 59 seats in the Illinois Senate are up

for re-election. Primaries are less than 16 months away, Dr. Freidheim added.

"We still need to work harder to increase the number of ISMS members who are willing to contribute the dollars and increase the number of ISMS members who are willing to work with and for medicine's candidates," Dr. Freidheim said.

ISMS members can join IMPAC when they renew their 1997 membership in ISMS, the AMA and their county medical society. Physicians may also watch for IMPAC mailings that seek financial support during various times of the year, Dr. Freidheim said. ■

ISMIE earns upgraded

(Continued from page 1)

only by raising premium rates to create profitability, "we'll be very happy staying with the rating we have."

A.M. Best financial analysts were also impressed with ISMIE's grasp of the changes in the medical insurance field and with its new products that provide physicians with one-stop shopping for their insurance needs, according to a presenter. These new products, introduced this year, were developed to offer coverage for the business side of practicing medicine. Included are a physician

business practice liability insurance policy to protect physicians from legal exposure in areas that aren't covered by medical malpractice insurance; a capitation stop-loss policy to protect physicians, groups and clinics that work with capitated contracts and might experience medical expenses beyond what their capitated payments cover; and two high-coverage policies available to member clinics and corporations. ISMIE also developed an employment practices liability insurance policy to protect physicians against losses stemming from wrongful termination, sexual harassment and discrimination claims. ■

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Illinois Medicine

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Happy
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Revised Medical Practice Act passes General Assembly

REVISION: Updated law addresses continuing medical education and disciplinary issues. BY JANE ZENTMYER

[SPRINGFIELD] On Dec. 4, the Illinois General Assembly passed the revised Medical Practice Act, the law that governs physician licensure and the practice of medicine in Illinois and is administered by the Illinois Department of Professional Regulation. The measure is now awaiting Gov. Jim Edgar's consideration. The Medical Practice Act of 1987 was scheduled to sunset at the end of 1997.

"We are pleased to see legislators move ahead with the

updated Medical Practice Act, which will strengthen the framework on which the department builds its efforts to serve Illinois patients," said ISMS President Sandra Olson, MD. "ISMS has been working with legislators and the department for over a year to develop an act that ensures IDPR will have the tools it needs to carry out its mission."

The Medical Practice Act, along with acts governing the practice of optometry and clinical

psychology, passed the House by a vote of 114-0 and the Senate by a vote of 55-0. Legislators who voted present were Rep. Jan Schakowsky (D-Evanston) and Sens. Earlean Collins (D-Chicago) and Alice Palmer (D-Chicago). If signed by Gov. Edgar, the act will sunset on Jan. 1, 2007. The legislation updates some of the language and incorporates related laws that were passed after the enactment of the 1987 Medical Practice Act. Changes also clarify and expand some current provisions.

Schakowsky and Sen. Donne Trotter (D-Chicago) introduced a bill in the House and the Senate to require IDPR to collect information on felony convictions, disciplinary actions and malpractice settlements against physicians and to make that information available to Illinois consumers through a toll-free
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'TIS THE SEASON

for fun and fund-raising at Lutheran General Hospital in Park Ridge, where the hospital's Service League is selling two-foot trees decorated by hospital staff. Service League administrative director Sandee Main (left) and Patricia Jacobsen show off a tree on display in the Beart Family Lobby.



Andrew Corrigan Halpern

New Ob/Gyn access law raises questions

IMPLEMENTATION: IDOI clarifies some issues, but others require contract review. BY JANE ZENTMYER

[CHICAGO] By now, many physicians know that a law that kicked in Nov. 14 gives women in managed care plans direct access to their obstetrician or gynecologist as their "principal health care provider" who can refer them to other doctors just as a primary care physician can. But as the law is implemented, physicians may have questions about specifics.

The new law addresses access and applies only to services covered by the policy or plan, without mandating specif-

ic services that should be provided by obstetricians or gynecologists, according to Mary Petersen, an insurance analyst with the Illinois Department of Insurance, which is implementing and enforcing the law. "[The services covered] are going to be determined by the contracts [doctors and patients] have with each of the managed care companies and what they say; and I think the companies are going to be contacting them about how they want to pro-
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Key elements of the Medical Practice Act

The following are some of the key elements of the revised Medical Practice Act:

- Requires 50 hours per year of continuing medical education for physicians.
- Requires physicians to respond in writing within 60 days of being notified by the Medical Disciplinary Board that a mandatory report has been filed.
- Requires the Illinois Department of Professional Regulation to notify physicians twice if a complaint has been filed against them – when the complaint is being investigated and when the investigation is completed.
- Defines as grounds for discipline "immoral conduct" that includes sexual misconduct.
- Allows for probation, fine, license suspension or license revocation to be imposed on physicians who fail to comply with state tax laws. Previously, only the latter two applied.
- Maintains the current license renewal fee at \$300 for a three-year license.
- Allows IDPR to place on the state World Wide Web site information about whether physicians have had disciplinary actions against them.

House approves bill to end 'drive-through mastectomies'

STATE ACTION: Measure requires insurers to cover minimum of 96-hour hospital stay. BY JANE ZENTMYER

[SPRINGFIELD] With a vote of 114-0, the Illinois House of Representatives passed a bill on Dec. 5 that would require insurers and health benefit plans to cover at least a 96-hour hospital stay following a mastectomy, eliminating "drive-through mastectomies," which have garnered media attention during the past several months. The ISMS-supported measure now goes to the Illinois Senate, which isn't expected to consider the bill until it reconvenes in 1997. HMOs and the insurance industry oppose the bill.

"I had several constituents who wrote to me complaining and sent me articles from the newspaper," said the bill's chief sponsor, Rep. Rosemary Mulligan (R-Des Plaines). She noted

that other legislators received complaints as well. "When the public demands that we do something, we try to respond. I introduced the bill in order to stop that practice or at least to let doctors have the flexibility of determining what the appropriate length of stay would be for someone who had a mastectomy."

The measure's other co-sponsors include Rep. Judy Biggert (R-Westmont), Rep. Carolyn Krause (R-Mt. Prospect), Rep. Tom Cross (R-Yorkville) and Rep. Mark Beaubien (R-Barrington Hills).

The bill allows physician discretion in determining the length of hospital stay for mastectomy patients. Coverage for a shorter stay is permitted if the
(Continued on page 2)



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AMA joins other groups to combat family violence at local level

COORDINATION: A joint response is the best way to resolve abuse. BY DEBORAH PREISER

[OAK BROOK] More than 250 health and justice professionals, social workers, advocates and other direct service providers met Oct. 30 through Nov. 1 at the Oak Brook Hills Hotel to forge an integrated response to family violence and abuse. The AMA and the American Bar Association joined the U.S. Department of Health & Human Services and the U.S. Department of Justice to sponsor "Family Violence: Building a Coordinated Community Response." The second in a series of five regional meetings being held across the country, the seminar was designed to help communities develop and implement strategies to reduce family violence.

"Our communities have a patchwork of services for victims that work independent of one another," said Timothy Flaherty, MD, AMA trustee, in his opening remarks. "We are here to build a coordinated team approach that will bring strengths to bear on problems of violence in cities and towns across America."

"You know the numbers, and you know the faces behind those numbers, because you have worked with or cared for these victims," Dr. Flaherty continued. "I know these victims too. I am a radiologist and I have seen — in stark, objective, black and white — the shattered bones, the blood clots in the brains,

the ruptured internal organs, the bullets in every part of the body."

Conference attendees from Illinois and six other Midwestern states were organized into 31 multidisciplinary teams. ISMS members who participated in the program were ISMS President Sandra Olson, MD; Kathryn Bohn, MD, Gail Williamson, MD; and Leonard Yang, MD. Between presentations, the teams were allotted time to work together on ways to prevent and intervene in cases of child abuse, domestic violence and elder abuse.

"Family violence is a problem that can best be solved on the community level," said Marna Tucker, chairman of the ABA's Commission on Domestic Violence. "Working together, local physicians, lawyers, social workers, victim advocates, civic leaders and police can use their resources and expertise to help victims and their families break the cycle of violence."

In a session on the ethics and confidentiality of reporting abuse, Susan Hadley, founder of the WomanKind agency in Minneapolis, urged health care providers to screen all their patients for abuse, not just "those who appear with a red flag." At three Minneapolis hospitals with which Hadley works, staff now ask all patients: "Are you now or have you ever been in a relationship where some-

one has hurt you physically, emotionally or sexually?" Victims want to be asked about abuse, she added.

WomanKind receives about 100 referrals each month from health care professionals at the three hospitals, Hadley said. Forty percent of the referrals are a result of inpatient screening, and 20 percent are from emergency rooms.

"I believe nurses and doctors are hesitant about asking questions because they are afraid of the next step," Hadley said. Those next steps, which she urged health care professionals to take, are to establish a safe, secure environment for possible abuse victims; interview them privately and assure confidentiality; and respect their fear of retaliation. "A woman's fear will govern everything she does."

An attorney with the Minneapolis-based Battered Women's Justice Project, Loretta Frederick, had more suggestions for aiding abuse victims: "Our job is to listen, provide support, offer options and, over time, offer help to victims of abuse." Women may try to leave abusive relationships seven to 12 times before making the final break, so health care professionals and others may have multiple opportunities to intervene and offer assistance, she explained. "At all times, you must respect her decisions, even if you don't agree. It's OK to say, 'I'm

afraid for you. You might be hurt.'"

Physicians, attorneys and clergy have an ethical obligation to keep the confidences of victims of abuse, she said. "It's so critical to society that we do everything to support these [confidential] relationships."

Frederick also discussed mandatory reporting laws, which she said she believes can increase risks including possibly escalated violence and injuries, and the possibility that the victim will not seek further treatment or be candid with the health professional. "Some states require that we report injuries from violence. We need to evaluate our interventions and assess whether what we do will increase the victim's safety as well as the offender's accountability."

James O'Brien, MD, the Margaret Smock Endowed Chair in Geriatrics at the University of Louisville, agreed with Frederick. Mandatory reporting of elder abuse had been the law in the three states where he practiced medicine, he said, adding that this mandate often conflicted with the patient's and the doctor's desire to maintain confidentiality. "Mandatory reporting is at odds with the Hippocratic oath to keep to thyself," he said. In addition, surveys indicate that mandatory reporting is less effective than educational programs in detecting abuse, he noted.

Summarizing the important role physicians can play, Hadley said, "Health care providers may be the first and only professionals in a position to recognize violence in their patients' lives." ■

Hepatitis B vaccines to be required for fifth-graders for 1997-98 school year

PROTECTION: New state law will apply to some 2-year-olds as well. BY DEBORAH PREISER

[SPRINGFIELD] Students entering fifth grade for the 1997-98 academic year will have to bring more than paper and pencils to school. New Illinois immunization regulations require all students entering fifth grade after July 1, 1997, to show proof that they've had three doses of hepatitis B vaccine, according to the Illinois Department of Public Health. In addition, proof of hepatitis B immunization must be shown by children who are 2 years or older and enroll after July 1 in prekindergarten programs operated by a school or school district, IDPH said.

The Illinois School Code was amended this year to include the hepatitis B immunization requirement. Children enrolled in the federally funded Head Start program were previously required by federal law to show proof of hepatitis B immunization.

The first two doses of vaccine must be given four weeks apart, and the third shot must be administered at least two months after the second. "Since it takes a minimum of three months to complete the three-dose series of shots, parents of children who will be affected by the new requirements should begin planning the immunizations now," said IDPH Director John Lumpkin, MD.

The law targeted fifth-graders because they're required by state law to have a physical examination before beginning the school year. That is a good time to begin or continue administering the vaccine to children, said IDPH spokesperson Tom Schafer. The vaccine will also offer

protection before children reach an age at which sexual activity and drug use may begin, according to IDPH. Most of Illinois' average 350 cases of hepatitis B per year occur in young adults who are sexually active and/or share needles in connection with drug use, Schafer said.

To help parents of the estimated 167,000 current fourth-graders in the state comply with the new vaccination requirement, some local health departments and school systems are teaming up and offering immunizations in the schools. In Sangamon County, for example, all 11 school districts except for Springfield have opted for a program of on-site immunizations offered by the county public health department, according to Jim Stone, director of public health at the Sangamon County Public Health Department.

Consent forms were sent to parents of all fourth-graders, offering to provide the series of three shots for a charge of \$6 per shot. No child will be denied the vaccination due to inability to pay, according to Stone. The first shots in the series were offered in early December, with the second scheduled for January and the third for April. The number of parents taking advantage of the offer varied from 30 percent to 98 percent depending on the school, Stone said. "The schools appreciate the proactive approach of the public health department," he added. "The task of monitoring all 1,400 fourth-graders in the county to make sure they get the shots at the right intervals would be much harder

without this program."

The Chicago Public Health Department typically holds special Saturday clinics in July and August for children who need school physicals and immunizations, according to spokesperson Tim Hadac. Noting that about 50,000 fifth-graders in the city will need their hepatitis B immunizations by the start of school next fall, Hadac said the department may start offering the shots this spring.

To gear up for the estimated 50,000 suburban fifth-graders who need the series, the Cook County Department of Public Health this month started separate Hepatitis B lines at 13 immunization clinics throughout the suburbs, according to department press material. The lines are intended to encourage those who already use public health clinics to start getting the hepatitis B shots now to avoid the long lines expected next summer.

Hepatitis B vaccine has been available since 1982 and has been included in the recommended Illinois childhood immunization schedule since 1991.

Allergic reactions to the vaccine are rare, Schafer said. "If a person has any reaction at all, it's soreness and mild to moderate fever."

Hepatitis B is spread by direct contact with the blood or bodily fluids of an infected person, with possible symptoms including yellowing of the skin and eyes, loss of appetite, nausea, vomiting, fever, stomach or joint pain and extreme tiredness. However, carriers of the disease may not know they have it or experience any symptoms. "It can be unwittingly spread to others this way," Schafer said.

The three-dose immunization requirement brings Illinois in compliance with recommendations from the American Academy of Pediatrics and the Immunization Practices Advisory Committee of the U.S. Centers for Disease Control and Prevention, according to IDPH. ■

House approves bill

(Continued from page 1)

attending physician determines that it is in the patient's best interest. A factor in that determination would be whether a patient has coverage for home health visits and follow-up office visits.

The bill also requires that patients be notified in writing about coverage of home and follow-up visits as part of routine coverage information and at admission to the hospital for a mastectomy. Insurers and managed care plans are prohibited from penalizing physicians who provide care in compliance with this bill or from reducing their reimbursement. Plans are not permitted to offer monetary incentives to patients or physicians to encourage them to shorten hospital stays, nor can coverage be denied to women solely to avoid the bill's requirements.

If passed by the Senate and signed by Gov. Jim Edgar, the measure will apply to all employees of state and county government, municipalities and school districts; enrollees in HMOs that do business in Illinois; and Medicaid recipients. The law also applies to self-insured entities in the private and public sectors. ■

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Local public health departments offer immunization assessments

ASSISTANCE: Physicians can get information to help them bolster immunization rates in their practice. BY JANE ZENTMYER

[CHICAGO] As part of an ongoing statewide effort to track and improve children's immunization rates, local health departments are offering assistance to private physicians through office assessments, education and consultation. The initiative focuses on improving immunization rates among children who are 2 years old and younger.

"We know we're not at the [immunization] level that we want to be, both in the public and private sectors where immunization services are provided," said Stephanie Smith, MD, director of communicable disease control for the Cook County Department of Public Health. "We have been addressing those issues in the public sector for several years now. At this point we're turning more attention to what we can do in the private sector to enhance immunization coverage."

The Illinois Department of Public Health distributed a total of \$2 million to participating health departments across the state this summer to implement the office assessments locally, according to Ralph March, chief of IDPH's immunization section. IDPH receives the money as part of a federal grant, which requires the state to track and improve immunization levels among private providers. The state program also attempts to reach the goal set in the national Childhood Immunization Initiative of increasing immunization coverage of 2-year-olds to at least 90 percent by 2000. "We're hoping that our local health departments may be a little more effective in getting cooperation than state government," March said.

The program is being conducted under the Medical Studies Act, which means that patient confidentiality is protected and the information collected cannot be used in a legal action, according to ISMS legal counsel. In addition, health care providers who furnish information cannot be subjected to any action for damages or other relief, counsel said. Local health departments have been supplied with forms called "declarations of medical study," which explain the use of the data and note that it will be kept confidential. Accompanying the form is an "acknowledgement of receipt" stating that the physician agrees to participate in the assessment and outlining that the agent reviewing records will read only the immunization history and won't take any notes that might identify the patient. ISMS legal counsel recommends that the forms be signed by physicians and agents conducting the audits.

Immunization rates at Sangamon County public health clinics have reached about 95 percent, according to James Stone, director of public health for the Sangamon County Department of Public Health. But those clinics see only about 20 percent of the county's 2-year-old population, he added. "Therefore, to get a good overall feel for the rate of immunization of 2-year-olds throughout the entire county, we're hoping to get the voluntary participation of local physicians' offices."

Local health departments can tailor

the program to fit the needs of physicians in their areas, but the overall goals and procedures will generally be the same, March said. Each will send staff out to conduct confidential office assessments of the physicians who request assistance. The data collected will be

used to determine the immunization rates among the children of that practice, identify any barriers that prevent higher immunization rates and suggest ways to bolster immunization levels, he said.

The program is voluntary, and physicians will not be penalized for any finding or recommendation, according to March. Any statistics compiled will be kept general so as not to identify a specific practice or physician, he added.

Health departments, which received funds based on factors such as birth rates, are implementing the program under varying time frames, said Richard Galati, public health program adminis-

trator in IDPH's immunization section. The Cook County Department of Public Health, which received a \$600,000 grant, began its program in mid-October. The department will continue enrolling interested pediatricians, family physicians and general practitioners in private practice in suburban Cook County until March 1997 and possibly longer. Through November, the department had conducted assessments in 22 private provider's offices. At least 10 assessments had been scheduled for December, and another 30 physicians had expressed interest in the program, according to Marcia Fahren-

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REPORT for Illinois Physicians

MATERNITY LENGTH-OF-STAY

Maternity length-of-stay has received a great deal of press in the past several months. Recent Illinois and federal legislation have added a layer of complexity to this important issue.

Blue Cross and Blue Shield of Illinois, along with many other carriers, encourages the shortest maternity length-of-stay consistent with sound medical judgement, leaving the decision in the hands of each attending physician. Data from each of our product lines strongly supports the integrity with which Illinois obstetricians and family practitioners address this issue. In each of our 3 main lines of business (HMO Illinois for which utilization management is delegated to each participating group, Blue Choice which is fully managed by BCBS clinical staff, and PPO which is less tightly managed) lengths of stay were nearly identical at slightly more than 1.5 days. We therefore believe that little will change in the future, since the decision maker remains the attending physician. We understand, however, that managed care plans elsewhere in the United States may have had more onerous policies. We should all take pride that in Illinois, physicians and Blue Cross Blue Shield network managers have worked well together and achieved good clinical and economic outcomes.

What about the future? We expect that there will be many misunderstandings based on the complexity of this issue. Few Illinois expectant mothers and fathers understand that:

1. The Illinois law only affects local Illinois insured benefit plans. Large, national benefit plans are exempt from Illinois law under ERISA;
2. The Illinois law only takes effect when the benefit plan renews after mid November, 1996.
3. The Federal law does not become effective until 1998.

Dealing with the expectations of your patients and our enrollees is a major issue for Blue Cross and Blue Shield of Illinois. We have developed messages for our enrollees, advising them of the law in language that we hope they can appreciate and understand. In all circumstances, however, at least for our enrollees, the length-of-stay decision for their maternity hospitalization will be based, as it has been in the past, on the judgement of their attending physician.

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EDITORIAL

After the holidays

In the sixth century B.C., the Chinese philosopher Lao-tzu wrote: "The sage does not accumulate for himself. The more he uses for others, the more he has himself. The more he gives to others, the more he possesses of his own." The idea that giving to others benefits the giver and the recipient is not new. But putting the concept into practice can be trying at times, especially during the holidays. After fighting swarms of shoppers and long lines in stores, even the most generous individuals can feel less than charitable.

Many physicians expand on the practice of holiday gift-giving by donating their services throughout the year to help the poor and those who lack access to health care. The experiences of three such doctors are described in the feature story in this issue. One of the physicians, a pediatric plastic surgeon, traveled to Panama on a mission sponsored by Operation Smile. The organization supports 28,000 medical volunteers who travel to 12 developing nations to provide \$28 million-worth of medical services yearly for children and young adults who have been disfigured by congenital defects, tumors and burns. In Panama, families traveled on foot for days to reach the surgical site, and only half of them could be accommodated.

In 1996, another philanthropic organization, Flying Doctors of America, completed 14 short-term medical missions to countries in which medical care

for the poor is scarce. The physicians interviewed by Illinois Medicine traveled to small villages in the Dominican Republic to treat several hundred people daily for such problems as parasites, arthritis and high blood pressure.

Right here in the United States, there are ways doctors and others can help those in need. New Eyes for the Needy provides free eyeglasses to people in the United States and abroad. The organization, based in Short Hills, N.J., accepts donations of plastic-framed glasses, categorizes them and sends them to developing countries, according to the Chicago Tribune. Metal frames are melted down so that the metal can be sold, with the proceeds funding eye exams and prescription glasses for low-income Americans.

The Lions Club accepts old eyeglasses and hearing aids for distribution to the needy and even takes donated medical equipment like wheelchairs to be loaned to people who can't afford them.

To help the hearing impaired, Denver-based HEAR NOW provides hearing aids and cochlear implants to Americans who meet federal poverty guidelines, the Tribune reported. Donated hearing aids are distributed or sold for parts to manufacturers who then sell discounted new aids to the organization.

Offering service to a low-income clinic in Illinois or an organization working abroad, or making the simple gesture of donating old eyeglasses, can benefit someone somewhere well after the holidays.

PRESIDENT'S LETTER

Medical education

Sandra F. Olson, MD



There are idealistic, dedicated young people who still feel the magical draw of medicine as a career.

The future of both undergraduate and graduate medical education has become a current topic of serious and sensitive discussion among members of the profession and the public. Medical school deans, students and recent graduates; legislators; national, state and specialty societies; and the American public all have a stake in the final outcome of this debate, which will ultimately shape the future of our American health care system. We will have to answer questions about the number of doctors we will need, their specialty orientation and their geographic distribution, as well as payment mechanisms for their training. It's not that those questions aren't being addressed — studies by the PEW Trust, AAMC, Council on Graduate Medical Education (COGME), Institute of Medicine and others have produced reports and proffered answers and solutions. The AMA is also looking at this issue and debating future directions in medical education. So now the real questions emerge: Who will decide — the payers, the government, medical educators, the public or all of the above? And what bases should be used to formulate the decisions?

The forces that have driven us to this point have been developing for many years; they include the explosive growth of medical scientific knowledge leading to increased specialization, essentially open-ended GME funding distributed without any consideration for medical specialties and the lack of comprehensive, objective work force planning. Now we're faced with the probability of too many doctors and specialists, worse geographic distribution of doctors and specialists and decreased funding for both undergraduate and graduate medical education. Medical schools increasingly depend on faculty practice income; training programs face government funding cutbacks; and decreased public and insurance funding has caused further financial hardships for academic inner-city hospitals, which are often the only medical resource for the poor. At the same time, tuition costs continue to escalate for students, and debt load rises yearly. With social pres-

ures to train more generalists, who usually face lower salaries and median income, the length of time an average student will need to generate the funds necessary for repayment will surely increase also. Yet the number of medical school applicants remains at an all-time high.

In spite of this uncertainty, the message is clear: There are idealistic, dedicated young people who still feel the magical draw of medicine as a career. The main drawing force of medicine is still the stimulating blend of exciting scientific knowledge and inquiry with the satisfaction and altruistic sense of helping others, especially those in need. That force is not predicated on financial reward, prestige or other tangibles. To be sure, doctors still enjoy these compensatory rewards, but they don't seem to be the prime reasons for a decision to become a doctor, which brings me to the young people contemplating medicine as a career or who have already committed themselves. What are they thinking and asking about the future?

I've had the opportunity to talk to several groups of students, largely in first- and second-year classes, at different schools around the state, and it's clear they are concerned about these same issues. They want to be able to choose a specialty and practice it where they like. They're worried about their ability to repay loans and have some financial stability. They're especially anxious about their ability to take care of their patients without undue restrictions, and they're insecure about potential adverse pressures on them. They are also interested in and involved in ethical issues, such social issues as end-of-life care and anti-violence initiatives, and medical care for the poor and underprivileged. Many even volunteer in related projects.

Medical education is going through a tumultuous and uncertain time. But the constants are the quality, dedication and unencumbered optimism of the fine young men and women choosing medicine today. Because of them, I think the future will be secure. We need to support them in any way we can.

GUEST EDITORIAL

Avoiding disciplinary problems

By Boyd E. McCracken, MD

The Illinois Medical Disciplinary Board fairly and conscientiously carries out three missions that I consider to be its mandate. They are protecting Illinoisans from physicians who violate the Medical Practice Act, protecting practicing physicians who have been falsely accused and using education as necessary to prevent future violations of the act.

During my tenure with the disciplinary board, I have seen recurring violations that reflect an unawareness of some of the regulations governing medical practice. Every physician should read and become familiar with the Medical Practice Act. Although the newly revised Medical Practice Act passed the General Assembly on Dec. 4 (see story, page 1), the information in this column is still relevant. Doctors should also read the Controlled Substance Act. Copies of both acts are available by calling the Illinois Department of Professional Regulation. Knowing these rules is as important as maintaining clinical skills.

The following are some suggestions that should help physicians avoid disciplinary problems:

- Always maintain proper, legible medical records on all patients. Physicians' best interests are served by documenting negative and positive findings as well as all recommendations made and treatments carried out. If these records are illegible to others, they might as well not exist.

- Enter all information in office, hospital or other health-care-facility records contemporaneously with the event they document. After-the-fact notations lose their credibility.

- Never alter a medical record after it has been written. The proper course is to use addenda that have been dated and separately signed.

- Know the law in regard to the transfer of medical records and comply with appropriate requests for copying or transferring records.

- Never presign prescription blanks. Preprinting or presigning any prescriptions for a controlled substance violates the Controlled Substance Act.

- Follow the specific regulations pertaining to dispensing drugs and maintaining drug logs if you dispense drugs.

- Know the specific rules pertaining



to physician's assistant privileges and how and when operating protocols must be used if you supervise a PA.

- Have a female attendant present when doing breast or pelvic examinations if you are a male physician.

The following actions violate the Medical Practice Act:

- Failure to report suspected child abuse. This also violates the Department of Children and Family Services Abused and Neglected Child Reporting Act.

- Gross and willful overcharging for professional services or inappropriate unbundling of fees.

- Failure to report to the Illinois Department of Professional Regulation a

health care institution's, professional organization's or governmental entity's adverse final action against the doctor, or an adverse liability judgment.

- Failure to furnish IDPR with legally requested information. A physician notified by IDPR that it has received a mandatory report of an incident is always best served by writing a letter explaining the nature of and circumstances around the incident. A simple letter can sometimes prevent further investigation.

Dr. McCracken is chairman of the Illinois Medical Disciplinary Board and has served on the board for five years.

LETTERS

Defending the corporate practice of medicine

Illinois Medicine has regularly covered lawsuits related to the corporate practice of medicine and has explained ISMS' policy, which states that such practice is contrary to the best interest of patients. I am concerned that ISMS and the AMA have not considered the implications of that policy for many physicians. The related provisions in Illinois law aren't the law in most states. Also, there are exceptions that make the corporate practice of medicine legal for certain entities in Illinois.

The system of employed physicians has existed for many years, and these physicians are employed out of choice. Isn't it appropriate for physicians to decide where and how they should practice medicine? Should ISMS and the AMA decide for them? In my opinion, no. The effect of such a policy on those physicians involved and their communities and patients could be catastrophic.

In Danville, criticism of the corporate practice of medicine has been fueled by physicians who have raised the issue that not-for-profit hospitals should not use their "tax-free dollars" to recruit and retain physicians. Most of the physicians criticizing this practice have benefited from not-for-profit hospitals or tax-free dollars at some

point in their medical careers. Would physicians who use the services of interns, residents and fellows be willing to pay to support these services and not use tax-free dollars? I doubt it. Would physicians subsidize services for indigent patients seen through not-for-profit hospital facilities? I doubt it. The real issue is unwanted competition, no matter how it is expressed.

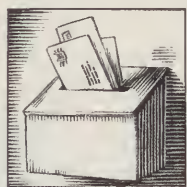
At no time has a hospital administrator told me how to practice medicine or restricted my practice. However, I will state that physician-controlled groups have attempted to restrict practice decisions for economic reasons.

A possible solution would be to clearly establish that all contractual arrangements with either physician-controlled or nonphysician-controlled entities mandate that the physician alone is responsible for all medical decisions in his or her practice of medicine and that those decisions cannot be compromised for economic reasons alone. This could be accomplished through state legislation.

ISMS and the AMA should represent all members equally by supporting freedom of choice for physicians. Majority decisions are not appropriate with respect to issues like the corporate practice of medicine.

— Marvin Hoovis, MD
Danville

Illinois Medicine reserves the right to edit all letters to the editor.



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ISMIE Update

Shorter hospital stays necessitate proper discharge planning

Physicians should give patients complete instructions and document that they've done so.

BY DEBORAH PREISER



With hospital stays decreasing from weeks to mere days, even for serious medical procedures like open-heart surgery, many patients are leaving the hospital in weaker condition and more vulnerable to complications than ever before. That means physicians should make sure that their patients understand exactly what they must do to continue their recovery. Patients need to know not only the dosage of their medications but also their diagnosis and any symptoms that could signal the need for immediate medical attention by the physician or in the emergency department. Instructions or information that is unclear may endanger patients.

"Before a patient leaves the hospital, the physician needs to take the time to let the patient know the diagnosis and findings," said Richard Snodgrass, MD, a cardiologist from Moline and a member of the ISMIE Risk Management Committee. "It really happens that some patients leave the hospital and don't have the foggiest idea of what the physician found – or if there's no diagnosis, what has been ruled out.

"The physician should then discuss what medications the patient is supposed to take, the dose and frequency, and write a prescription right then," continued Dr. Snodgrass. "That way, patients can have the medication as soon as they go home." Discharge instructions should also include specific side effects to look for, diet and activity guidelines, follow-up lab tests that need to be done and information for the patient to schedule an office follow-up appointment, he explained. "We include the office telephone number to make it more convenient for the patient to make the appointment."

Dr. Snodgrass said that before his patients who are on anticoagulant drugs leave the hospital, he routinely arranges for lab tests to be done five to seven days after the patients' discharge. On a prescription pad, he writes information for the patient to take to the lab: the date the tests should be done, the name of the needed tests and instructions for the lab to call his office with the test results. He said he also instructs patients to call his office after their tests. "If there's a need to change the medication dosage, we handle it right away. It does no good to do a test and not follow up."

"Most hospitals have protocols in place to help physicians with discharge planning," said attorney James Neville, of Neville, Richards, DeFranko & Wuller in Belleville. "The written discharge orders should be signed by the patient, a family member or other responsible person. Another good practice is to have the nurse who goes over the instructions with the patient sign the discharge orders. Before a patient is actually discharged, the doctor should also discuss the discharge instructions with the patient and document this discussion in the handwritten progress notes."

In the discharge orders, be as specific as you can be about the symptoms of a complication or

worsening condition, said attorney Rudy Schade of Cassiday, Schade & Gloor in Chicago. "Caregivers as well as the patient ought to be aware of what to be looking for." Schade stressed the importance of documenting what instructions were given and to whom. "The failure to document the fact that instructions were given could cause problems for the physician if there's a complication later on."

Preprinted forms from the hospital can serve as a checklist for the physician and provide detailed instructions for the patient. One standardized discharge form from a radiology department, for example, spells out specific warning signs for patients: "If you cough up or vomit blood, have dark tar-like bowel movements, or have chest pain, shortness of breath or fever, please call [the hospital's number] and ask for the radiology resident on-call or go to your local emergency department."

"Not all discharges are as

orderly as you would like," said Richard Geline, MD, an orthopedic surgeon in Skokie and chairman of ISMIE's Risk Management Committee. "It's not a perfect world. Residents discharge patients on nights and on weekends. With the pressures of managed care, you get calls from utilization review people who want to discharge a patient. What's important is that you know what the ideal discharge situation is, and if circumstances dictate that there are gaps in the process, determine what level of aggression you need to pursue to make up for it. That can mean calling patients directly to make sure they understand your instructions or sending a note. Then document what you did."

Neville said that if possible, discharge orders should do more than suggest a follow-up date for patients to see their physician. "It may take some more coordination, but it's a good idea to actually schedule the follow-up appointment with the doctor's office as well as schedule specific follow-up tests. That way, the follow-up is not left to the patient, and there's less likelihood of the patient getting lost in the cracks."

Copies of the discharge orders and scheduled appointments should be placed in the hospital chart, given to the patient and sent to the physician's office, Neville said. Then,

if a patient fails to keep an appointment, a follow-up procedure such as a phone call or a written note can be triggered more easily, he added.

Discharge orders should also be legible to avoid miscommunication, according to risk management specialists.

Given the fact that hospitals are discharging some patients sooner than they would have in the past, physicians should make certain that patients have arranged for continued care at home. "A doctor has the responsibility to inquire about caregiving," said Schade. "You cannot discharge patients and leave them on the steps. As hospitals move people out faster, caregiving from family members or home health professionals will have to become more sophisticated."

When he started as a cardiologist 20 years ago, most open-heart surgery patients spent at least 10 days in the hospital, Dr. Snodgrass said. Today, that stay has dropped to an average of six days. Shorter hospital stays mean more and more patients are going home needing oxygen therapy, intravenous drug treatments and feeding tubes in the home setting, according to Dr. Snodgrass. "These things just don't happen. They need to be planned. Extended-care facilities where patients stay for one to three weeks are helping to bridge the gap between the acute care hospital and home." ■

MALPRACTICE ROUNDUP

Hospital not liable for foot amputation

The District of Columbia Court of Appeals affirmed a trial court ruling that a hospital was not liable for the amputation of a patient's foot, because the evidence did not establish that the attending physician's conduct led to the amputation, according to the October 1996 issue of the Hospital Litigation Reporter.

Following an automobile accident, the plaintiff was taken to D.C. General Hospital for treatment of traumatic injuries. A splenectomy was performed several days after the accident. After the splenectomy, a blood clot formed above the patient's right ankle; blood flow was blocked to the patient's right foot; gangrene developed; and the foot was partially amputated. The patient filed suit against the hospital alleging that failure to properly administer aspirin after the splenectomy allowed the clot to form, causing the gangrene and leading to the amputation.

However, the plaintiff's expert admitted that the exact location of the clot's origin could not be pinpointed. The expert also acknowledged that the patient suffered from arteriosclerosis, which could have caused the blood clot. The court found no evidence to show that the blood clot formed following the splenectomy, and no testimony showed that aspirin could have stopped the blood clot. ■

Illinois docs bring medical care, training around the world

Physicians find rewards in helping patients who lack access to care.

BY DEBORAH PREISER



In a makeshift surgical suite in rural Panama, Frank Vicari, MD, performed surgery that helped a 30-year-old woman and her 55-year-old father smile for the first time. "They had lived their whole lives with gaping holes in their upper lips, cleft lips that had never been repaired," Dr. Vicari said. "The family never had another option. It was just staggering to see."

The medical mission was part of Operation Smile, an international volunteer medical services organization that has repaired the faces of about 39,000 children and young adults disfigured by congenital defects such as cleft lips and palates, as well as tumors and burns. The organization, based in Norfolk, Va., was founded 14 years ago by plastic surgeon William Magee Jr., MD, and his wife, Kathleen Magee, a nurse and social worker.

In January 1995, the team traveling to Panama included Dr. Vicari, a pediatric plastic surgeon at Children's Memorial Hospital in Chicago, and fellow Chicagoans pediatric anesthesiologist Mike Tobin, MD; pediatric orthodontist Ron Jacobson; Beth Nielson, RN; Rachel Rosen, RN; and writer Ira Paul Rosen as well as medical professionals from North Carolina. The team corrected cleft lips and palates and performed surgeries to correct burn scars and congenital deformities such as talipes and webbed fingers on 150 patients who otherwise wouldn't have had access to such care.

An advance team screened some 300 individuals in David, the capital of Chiriqui Province, to find the most severe cases. The Guaymi Indian families hoping for a surgical slot had traveled on foot for days through the mountains to reach David.

Then for five days medical team members worked from 6 a.m. until 9 p.m. alongside their Panamanian counterparts teaching them intricate surgical skills while operating under less-than-ideal conditions.

"We overwhelmed their system," Dr. Vicari said.

"The hospital was never designed to handle the number of surgeries we performed. We had six surgical suites operating at the same time. The generators would go down, the lights off, and we would be operating by flashlight. We took tons of equipment with us, but it was not enough. We made do with whatever we had."

Although the families were grateful to the team, there were other benefits for Dr. Vicari, who is working to establish a Chicago chapter of Operation Smile. "Any-

body who operates on kids knows parents everywhere are grateful. What was fun for me was the camaraderie. It was like being back in college on a sports team. We all worked really hard to help these people."

"It's one thing to perform the surgeries and return home," said Rachel Rosen, a certified plastic surgical nurse. "We weren't just giving them our time; we were giving the doctors and nurses there the knowledge they needed to do the same work themselves."

"The nurses from Panama were well educated," Rosen said. "But they had no supplies and no specialized training. They were appalled at what we waste—there we used the same suction tubes over and over, just taking time to disinfect them between surgeries."

Operation Smile is planning missions to Nicaragua, Vietnam, Honduras, China, Russia, Romania, Panama, the Philippines and the Middle East in 1997.

Last June, Operation Smile received the first annual \$1 million Conrad N. Hilton Humanitarian Prize, from the nonprofit Conrad N. Hilton Foundation in Los Angeles, which makes "significant contributions to easing human suffering," according to foundation background.

The chance to practice medicine without time-consuming paperwork enabled Ron Holt, MD, an emergency physician at Saint Mary of Nazareth Hospital Center in Chicago, and his fellow doctors to see several hundred people a day in small villages in the Dominican Republic in September 1995.

Dr. Holt and his wife, Barbara Scanlon, a surgical nurse supervisor at Central DuPage Hospital, participated in a medical mission sponsored by Flying Doctors of America, a nonprofit organization founded in 1990 and based in Atlanta. During 1996, Flying Doctors completed 14 medical missions to Mexico, Guatemala, Venezuela, Peru, India, Thailand and the Dominican Republic.

"When villagers heard that American doctors were coming to their town, the whole village crowded around the school houses where the medical teams would be setting up," Dr. Holt said. "By the third day, we learned it would work better to hand out numbers; it worked a little like a delicatessen. We treated chronic medical problems mostly—a lot of fungal infections, parasitical problems, arthritis and high blood pressure.

(Continued on page 10)



Performing surgery on a child in David, Panama, are Dr. Vicari (left) and Rosen.

Photo courtesy of Rachel Rosen



Photo courtesy of Terry Hatch, MD

Dr. Hatch (center) is surrounded by some of his patients and a peace corp volunteer in the Dominican Republic.

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Illinois docs

(Continued from page 7)

When we had patients with a cleft palate, we referred them to a hospital in a city. The Dominican Republic has a system of socialized medicine, so cost is not an issue. It's more of a logistical problem. The hospital was four hours away by car, but no one has a car."

Dr. Holt and Scanlon are returning to the Dominican Republic this month. "We do not save a lot of lives, but we create a lot of good will," Dr. Holt said.

A veteran of three Flying Doctor trips to the Dominican Republic, Terry Hatch, MD, a pediatric gastroenterologist at Carle Foundation Hospital in Urbana, said, "After 24 years in practice, I feel this is part of my task as a physician. I really have enjoyed it. This is a much better vacation than going on a cruise or staying at a resort.

"The Dominicans are great people — very poor, but not poor in spirit," Dr. Hatch continued. "We do see the products of extreme poverty, some forms of malnutrition, for example. But for the most part, we treat the aches and pains that come with chronic hard work." ■

Ob/Gyn access law

(Continued from page 1)

ceed with this."

Doctors and patients should review their managed care contracts for questions regarding the numbers of visits covered or reimbursement or billing issues.

Physicians may wonder when they and their patients need to start complying with the law. Compliance must occur as plans are amended, issued, delivered or renewed following the November implementation date. "For example, Jan. 1 is a pretty common date for group contracts to renew," said Ron Kotowski, IDOI assistant deputy director. "Under those contracts, the law wouldn't really pertain until that particular [renewal] date. For any new contracts, it would be effective immediately."

Kotowski explained how referrals should work: "The Ob/Gyn can refer the woman to literally anyone within the network that they want without sending them back to the [primary care physician]," he said. But the plans "could require preauthorization from the medical director of the managed

care plan."

For example, an obstetrician or gynecologist who diagnoses a woman with cervical cancer can bypass the primary care provider to refer the patient to an oncologist, he said. But the health plan can approve or deny the referral under its existing referral rules and procedures, Kotowski added.

The law states that women must be able to designate a participating principal health care provider who is defined as a "physician licensed to practice medicine in all of its branches specializing in obstetrics or gynecology."

MANAGED CARE PLANS and women have some options available to them as the new law is implemented, according to ISMS legal counsel. Plans must allow women to choose a principal health care provider. But plans can permit women to choose one physician to serve as both their principal health care provider and their primary care physician, or to select two different physicians, with one being a principal health care provider and the other their primary care provider. If women fail to choose a principal health care provider, however, they will not be

assigned one by the plan.

Besides managed care plans, the law applies to Medicaid; state, county, municipal and other governmental bodies; and ERISA-exempt employee or employer organizations, according to the Department of Insurance. The law defines a managed care entity as "any entity including a licensed insurance company, hospital or medical service plan, HMO, limited health service organization, PPO, third-party administrator, an employer or employee organization, or any person or entity that establishes, operates or maintains a network or participating providers."

"I believe it's going to be difficult for a while to determine that [women] have access," Petersen said. The Department of Insurance is requiring plans to drop any language from their contracts, including those with physicians, that is contrary to this law, she added. Petersen advised physicians who believe a managed care plan is not complying with the law to first try to resolve the issue with the plan. Doctors who remain unsatisfied should write to the Illinois Department of Insurance at 320 W. Washington, Springfield, IL 62767. ■

Medical Practice Act

(Continued from page 1)

hot line. The bill is currently stalled, but in a news release from the Families Advocating Injury Reduction, the sponsors said they will reintroduce the bill next session if necessary.

"These are warmed-over versions of proposals that in past sessions have been repeatedly recognized as redundant and ineffective," Dr. Olson said. She added that information on disciplinary actions taken by IDPR is already accessible to the public and, under the new act, may also be accessible through the Internet.

IN KEEPING WITH A POSITION of the ISMS House of Delegates, the Society currently provides county medical societies with the names of disciplined physicians and a request to investigate their qualifications for continued membership. Adverse decisions are published in Illinois Medicine, provided to ISMIE for its records, maintained and updated in ISMS files and submitted to the AMA for its consideration in case physicians apply for membership in another state.

The timing of the passage of the revised Medical Practice Act rankled some legislators. Sen. Vince Demuzio (D-Carlinville), who voted for the measure, said that lawmakers should have waited until the state auditor general's special report on physician disciplines was completed. "My thought was we ought to wait until we've seen that audit this spring to determine if there are any meaningful changes that we ought to attempt to make. If we're going to make public policy, let's talk about it. There was no discussion."

"Doctors believe this issue is important enough to justify immediate action," Dr. Olson said. "It is essential that [IDPR] have adequate time to put into place the systems needed to implement the act and that individual physicians have time to become familiar with and responsive to its requirements." Dr. Olson explained that the development of rules is a lengthy process and that if the act had been passed in the spring of 1997, there might have been too little

time for physicians to be notified of changes before the new requirements became effective.

The act requires physicians to get 50 hours of continuing medical education per year to renew their state medical licenses. "Illinois has a current requirement for CME, but it has no stated number of hours, so it's not enforceable," explained Joan Cummings, MD, chairman of the ISMS Council on Education and Health Workforce, which deals with education, licensure and disciplinary issues. Most states already require between 20 and 50 CME hours annually, she added. "We were one of only a handful [of states] or fewer that didn't have a specific hour requirement for CME."

The law doesn't specify exactly how physicians should meet the 50-hour requirement, but that will be addressed during the implementation process, according to Dr. Cummings.

Both the current and revised acts state that in determining what types of education can be used to meet the CME requirement, IDPR will consider educational requirements for professional associations and specialty societies. "Most doctors probably get more than 50 hours of continuing medical education per year whether it is formal, such as through courses, or on an informal basis such as through consultations, conferring with colleagues, journal readings and so on," Dr. Olson said.

Quantifying CME hours will help prove to patients that physicians are committed enough to providing high-quality patient care that they are willing to follow a specific standard, Dr. Cummings said.

Some of the proposed changes to the Medical Practice Act further explain disciplinary rules and procedures. One change requires physicians to respond in writing within 60 days of being notified of the Medical Disciplinary Board's receipt of a mandatory report, said Boyd E. McCracken, MD, chairman of the board. Mandatory reports are required under certain circumstances, such as when hospital privileges are curtailed or payments are made in malpractice actions. Under the current procedures,

the board sends a letter to physicians asking them to respond to the report. "Some respond, and some don't," Dr. McCracken said.

"Physicians could really shorten the whole process if they simply responded to the letter," Dr. McCracken continued. Without an explanation, the board must investigate the details of the matter, which could waste the board's and the physician's time. However, an explanation of the circumstances that led to the mandatory report often closes out the case and precludes an investigation because it reveals that the physician didn't violate the Medical Practice Act, according to Dr. McCracken.

When a patient or another member of the public files a complaint against a physician, the Medical Disciplinary Board will be required to notify the physician twice — when the complaint is being investigated and when the case is closed, Dr. McCracken explained. Although physi-

cians are now informed about such complaints, the proposed change would formalize the notification process.

Other changes include clarifying as grounds for discipline the definition of "immoral conduct" to include sexual misconduct, whether criminal or not, according to the judgment of the Medical Disciplinary Board, Dr. McCracken said. Under the new act, physicians who fail to comply with state tax laws will face probation, fines, license suspension or revocation. Previously only the latter two actions were possible.

The act also allows for information about whether physicians have had disciplinary actions against them to be placed on the state's World Wide Web site. Consumers may then call IDPR for more information.

The revised act makes no substantial changes to the state's current licensing procedures. The license renewal fee will remain at \$300 for a three-year license. ■

Local public health

(Continued from page 3)

wald, the department's project coordinator for the infant immunization initiative.

The Sangamon County Department of Public Health, which received about \$21,000 for its program, plans to begin implementation at the end of January or the beginning of February, Stone said.

Physicians may choose how many files they want reviewed, according to IDPH. They may opt to have the department pull 20 percent of the practice's records as a representative sample, for instance, or they may request a review of all the practice's records. Office disruption during assessment will be minimal, Dr. Smith said.

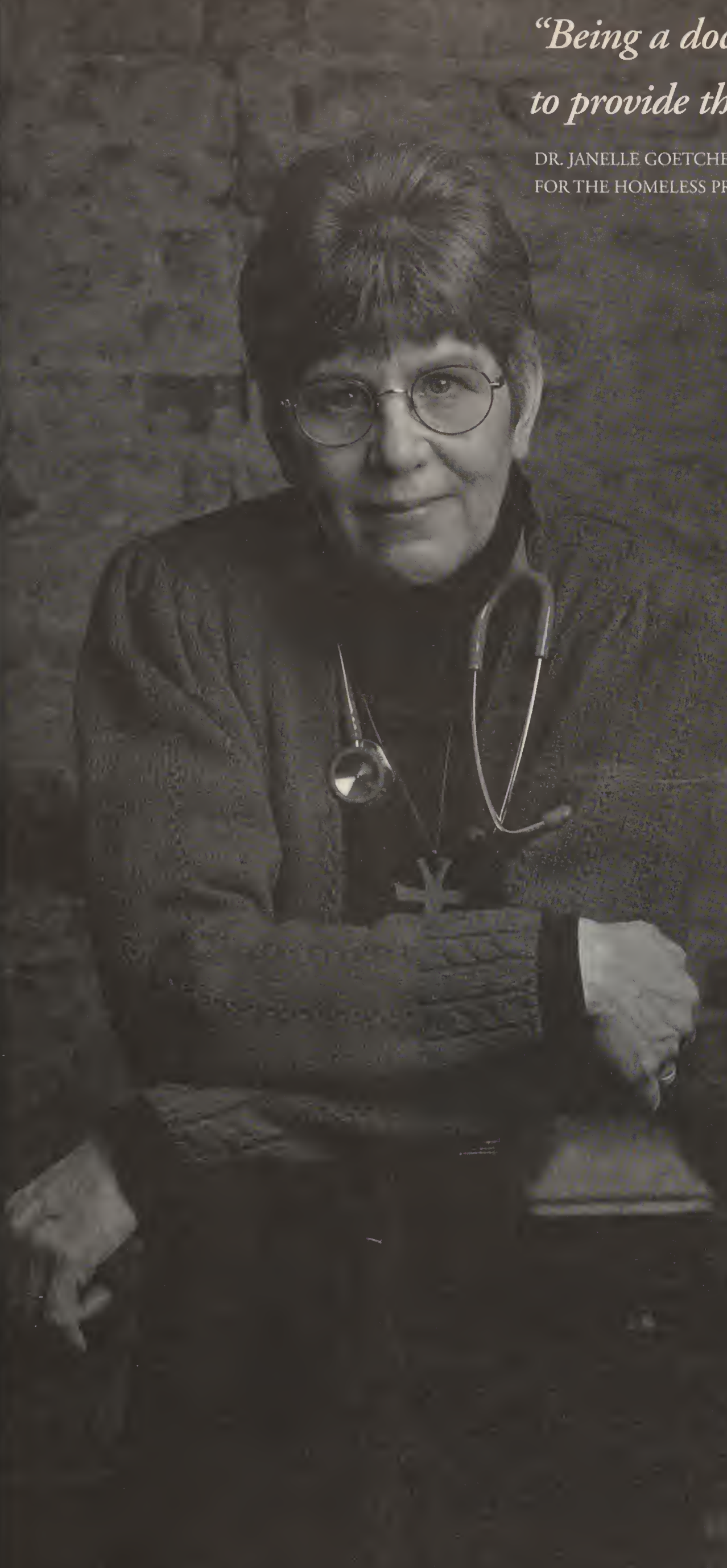
Some barriers to high immunization levels are related to "missed opportunities," according to Dr. Smith. Physicians may be used to giving immunizations only during well-child checkups and not during other office visits. A child who visits a physician for a middle-ear infection could get needed shots during a routine follow-up for the infection, she explained.

"Studies have shown that most physicians overestimate the immunization

compliance rates within their practice," said Mark Rosenberg, MD, a pediatrician with the Pediatric Specialists of Barrington and chairman of the Government Affairs Committee for the Illinois Chapter of the Academy of Pediatrics. Once an assessment gauges the actual immunization level, "there are opportunities within the assessment project to help physicians correct problems and raise the levels," Dr. Rosenberg said.

Assessments also include a follow-up visit, during which the health departments can provide physicians with a report detailing the practices' immunization levels and suggesting areas for improvement. "We can show them specifically which children in their practice were in their office and received some immunizations but were not given all the immunizations that they needed at that particular time," Fahrenwald said. "This kind of specific practice feedback really does help the physician to identify those problem areas that they want to work on and to develop strategies that are useful for their practice and will boost their immunization coverage levels."

For more information, physicians may contact their local public health department or call IDPH at (217) 785-1455. ■



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